Public Finance & Performance Committee

Wed 17 September 2025, 14:00 - 15:15

Virtual - MS Teams

Agenda

14:00 - 14:05
5 min

1. Standing Items

1.1. Welcome & Introductions

John Union

1.2. Apologies for Absence

1.3. Declarations of Interest

John Union

1.4. Minutes from the Finance & Performance Committee meeting - 23.07.2025

John Union

1.4 Public Finance and Performance Minutes 23.07.2025.pdf (10 pages)

1.5. Actions following the Finance & Performance Committee meeting - 23.07.2025

John Union

1.5 Public Action Log.pdf (2 pages)

1.6. Chairs Actions since previous meeting

John Union

14:05 - 15:05
60 min

2. Items for Review & Assurance (14:05 - 15:05)

2.1. Financial Report - Month 5 Position (including savings tracker) (30 MINUTES)

Andrew Gough

2.1 - M05 Finance Report.pdf (20 pages)

2.2. Operational Performance Update (20 MINUTES)

Paul Bostock

2.2 - Finance and Performance - Operational Performance Report Sept 25.pdf (11 pages)
2.2a - Integrated Performance Report F&P committee Sept 25.pdf (16 pages)

2.3. Board Assurance Framework - Long Term Finance (10 MINUTES)

Catherine Phillips

2.3 - BAF - Long Term Financial Sustainability F&P Committee 17.9.25.pdf (5 pages)

15:05 - 15:15

3. Items for Approval / Ratification (15:05 - 15:15)

10 min

3.1. Business Case for Information: Llantrisant Health Park OBC1 (5 MINUTES)

Catherine Phillips

Item is for noting

- 3.1 LHP OBC cover report Sept 25 Committee.pdf (4 pages)
- 3.1a - LHP OBC.pdf (135 pages)

15:15 - 15:15 0 min

4. Items for Information and Noting (15:15 - 15:15)

4.1. Monthly Monitoring Return - Month 3 & 4

- 4.1 WG 2025 _26 month 3 MMR Covering Report.pdf (2 pages)
- 4.1a CV Financial Monitoring Returns 2025-26 - Month 3.pdf (12 pages)
- 4.1b 2024-25 MMR Template - Cardiff Vale UHB Month 3 (1).pdf (4 pages)
- 4.1c WG 2025 _26 month 4 MMR Covering Report.pdf (2 pages)
- 4.1d CV Financial Monitoring Returns 2025-26 - Month 4.pdf (12 pages)
- 4.1e 2024-25 MMR Template - Cardiff Vale UHB Month 4.pdf (4 pages)

4.2. 2025 / 26 Financial Position CAV UHB

Andrew Gough

- 4.2 - 2025-26 Financial Position - CAV UHB.pdf (2 pages)

15:15 - 15:15 0 min

5. Any Other Business

John Union

15:15 - 15:15 0 min

6. Private Agenda

1. South East Wales Regional Orthopaedic Plan

15:15 - 15:15 0 min

7. Review & Closure

7.1. Items to be deferred to Board / Committee and review of any actions to future meetings.

7.2. To note the date, time and venue of the next Committee meeting: Wednesday 22nd October 2025 via MS Teams

15:15 - 15:15 0 min

8. Declaration

John Union

To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960]

Minutes of the Public Finance & Performance Committee Meeting
23 July 2025
Via MS Teams

To view a recording of this meeting, please click here.

Chair:		
John Union	JU	Independent Member – Finance / Committee Chair
Present:		
Charles Janczewski	CJ	CAV UHB Chair
Ceri Phillips	CP	CAV UHB Vice Chair
Sara Moseley	SM	Independent Member – Third Sector
Susan Lloyd-Selby	SLS	Independent Member – Local Authority
Rhian Thomas	RT	Independent Member – Capital & Estates
Mike Jones	MJ	Independent Member – Trade Union
David Edwards	DE	Independent Member - Digital
In Attendance:		
Matt Phillips	MP	Director of Corporate Governance
Andrew Gough	AG	Deputy Director of Finance (Strategic)
Claire Beynon	CB	Executive Director of Public Health
Adam Wright	AW	Director of Operational Planning & Performance
Ash O'Callaghan	AO	Head of Strategic Planning
Observers:		
Rachel Broome	RB	Finance Business Partner
Ian Virgil	IV	Head of Internal Audit
Secretariat:		
Nikki Regan	NR	Corporate Governance Officer
Apologies:		
Catherine Phillips	CP	Executive Director of Finance
Steve Riley	SR	Independent Member – University
Rachna Upadhya	SU	Independent Member – General

Ref:	Agenda Item:	Action:
FPC 23/07/1.1	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
FPC 23/07/1.2	**Apologies for Absence** Apologies for Absence were noted. **The Finance and Performance Committee resolved that:** a) Apologies for Absence were noted.	
FPC 23/07/1.3	**Declarations of Interest** The IMTS declared an interest for item 3.1 as the new Chair of Velindre NHS Trust.	
FPC 23/07/1.4	**Minutes of the Finance and Performance Meeting held on 18th June 2025** The minutes of the meeting held on 18th June 2025 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 June 2025 were held as a true and accurate record of the meeting.	
FPC 23/07/1.5	**Actions following the Finance & Performance Meeting on 18th June 2025**	

	5 items on the action log – all marked as complete. The DOPP noted the stroke measures will need to come to the next F&P committee meeting. **The Finance and Performance Committee resolved that:** a) The Action Log for the Finance and Performance Committee was noted.	
FPC 23/07/1.6	**Chairs Action since previous meeting** There were no Chair's Actions taken since the last meeting	
FPC 23/07/2.1	**Financial Report – Month 3 Position (including savings tracker)** The DDF gave an update on the financial report at month 3 and highlighted the following: • **Deficit Position**: Reported deficit at month 3 is £15.216m, which is £1.158m over the planned deficit. • **Savings Programme**: Shortfall of £844k to date against the £32m annual savings target; £28.6m of green/amber schemes identified, leaving a £3.4m gap. • **Operational Deficit**: Operational overspend of £314k to date, mainly due to mental health out-of-area placements, contract underperformance, and changes in patient mix (more Cardiff & Vale patients in critical care). • **Mental Health Placements**: Out-of-area placements peaked at 19 in month 2, now reduced to 9; regional/national solutions being explored. • **Contract Underperformance**: Noted in CAVOC and cardiac contracts; more CAV patients in critical care impacts income. • **Clinical Board Accountability**: Clinical boards are expected to meet control targets; weekly reviews are held to address red pipeline savings and operational pressures. • **Assurance**: No full assurance yet that actions will offset the deficit; granular dates for red pipeline schemes are being sought. • **Timeline for Action**: Committee stressed urgency—action plans and Plan B to address operational pressures must be set before September, with updates to be shared outside formal meetings if needed. • **National Pressures**: Shortfall in National Insurance funding (15% underfunded, £1.4m impact), CHC growth, and JCC commissioning pressure (£200k) are new or ongoing risks. • **Pay Awards & Risk Pool**: Pay award assumed fully funded; Welsh Risk Pool may add £6.6m risk, and Band 2–3 corrective payments could add £5.8m risk—neither covered in current plans. • **Workforce**: 50 whole time equivalent reduction between April and June; further reductions expected from voluntary early release schemes. • **Non-Pay Growth**: Largest increases in secondary care medicines and prescribing; CHC and commissioned services also rising. • **Savings Delivery**: No slippage on green/amber schemes; 40% of red pipeline schemes must be delivered to fully de-risk the plan. • **Key Risks**: Red risks include delivery of the £9.1m deficit target control total, £32m savings target, operational pressures, cash management, Welsh Risk Pool, and Band 2–3 payments. • **Risk Reduction**: Risk against the original plan has dropped from £23m when plan was submitted to £3.4m at month 3, but full assurance depends on closing the savings gap and managing operational pressures. • **Underlying Deficit**: If the plan is delivered, underlying deficit reduces to £56.2m; if not, it could rise to £62.9m in 2026/27. This will be updated monthly. • **Cash Position**: Strategic cash support from Welsh Government will be needed; £110m in allocations still to be received but pay award and NI cash now confirmed. • **Public Sector Payments**: Compliance at 95.8% at end of June. • **Committee Actions**: Committee noted the report, acknowledged the operational and savings challenges, and requested ongoing updates, especially in the absence of an August meeting. Regan,Nikki 17/09/2025 09:38:04 The CC questioned the £314k operational overspend at month 3 by asking if the clinical boards currently overspending were expected to recover their position, or if areas that have underspent will continue to do better financially. He specifically inquired about the approach being taken to address this variance and whether budgets are being reallocated or if expectations remain for all boards to meet their targets	

The DDF responded that clinical boards were still expected to hit the control targets which were set at the start of the year, even after submitting the revised plan. He clarified that boards showing improvement (notably PCIC and Mental Health) were expected to maintain those gains. Weekly meetings with all clinical boards are being held, reviewing schemes line by line to close the savings gap and mitigate operational pressures.

The UHB Chair reinforced the CC's point by stating that the committee is seeking assurance that the actions in train will deliver what was expected. He asked the DDF how confident he was that these actions will allow the committee to claw back even a small deficit position and not exacerbate it throughout the year.

The DDF stated he could not give assurance that the actions would offset the position, as he does not have his own assurance yet. He mentioned there was a long list of red schemes that, from their presentation, should start to deliver, and emphasized the need for granular dates so these can be built into the profile plan to provide assurance that they will be offset.

The UHB Chair focused on the operational overspends, asking what needs to be done to curtail them and whether there is confidence that the clinical boards fully understand the financial implications for the health board. He also questioned if there is an understanding of why the clinical boards are overspending.

The IMTS focused on the operational position, noting that some capital, estates, and facilities operational pressures are probably unavoidable due to what is happening in the estate. She mentioned that primary, community, and intermediate care (PCIC) is very significant. She highlighted the issue of determining when operational pressures reach a point where replanning is needed, emphasizing the importance of having enough time in the financial year to recover the position, and warning that the later this is left, the more difficult it becomes.

The DOPP explained that while there are some key areas with operational pressures, many areas are delivering better than their operational position. He expressed reasonable confidence that the positions in specialists and medicine can be recovered but emphasized that mental health remains the biggest challenge and the area with the least confidence for recovery.

The IMLA highlighted the critical issue of timescales, questioning at what point a decision would be made if operational pressures in a particular area continue. She suggested that planning for a parallel solution should be happening now, so that if those pressures persist or increase, there is a Plan B ready to implement. She specifically asked if that parallel process is happening.

The DDF stated that they are constantly looking at choices that can be made immediately and emphasized that operational pressures and the savings programme are essentially the same conversation. He explained that every idea to offset operational pressures goes through their red pipeline, and they are pushing to get decisions and dates on those actions now so they can deliver cash out if operational pressures continue.

The IMLA asked if there is a deadline set for when the dates need to be provided for the actions discussed.

The DDF confirmed that clinical boards will be set deadline for closing savings plan gap yet through the Senior Leadership Team (SLT).

The VC reinforced the importance of addressing the timing issue, noting that pressures will not get easier in quarters 2, 3, and 4, and emphasized the need to achieve equilibrium at this point. They referenced that last year the organization was unable to recover. Ceri also raised concerns about cost pressures outside of their control, such as continuing healthcare, and asked how the Health Board is lobbying Welsh Government to ensure the allocation provided can help mitigate these pressures.

The IMLA she was aware this was putting lots of pressure on staff and having to make difficult decisions and she wondered if it would be beneficial to have these discussions brought in to People & Culture and is there anything more we can do to support staff?

The UHB Chair agreed this was an important point as our staff need to be looked after but we need to look at the ask that is being asked of us. We need to consider what options are available as a board as it is important to understand the pressures.

	The IMCE asked with pay being such a large part of the bills and asked what our expectations of being for pay awards and whether WG are funding? She attended the Welsh risk pool meeting and noted the magnitude of settlements and many more will be coming through and it was suggested the bill for Welsh risk pool would increase in year. The DDF noted that the Risk Pool assessment was through NWSSP. The Welsh risk pool has a high number of cases being brought forward into 25-26 and CAV's share would be £6.6m and is now included in the risk table. WG is aware that no orgs have coverage for their share of £40m. The IMTU added another risk and wondered if we had confirmation that money would be available for band 2/3. The DDF noted this was included in the risk table. It would be a similar figure to Welsh risk pool. WG do not have the coverage in their plans. He would keep the committee informed as this is progressing. He further highlighted the following: • CAV UHB continued to reduce workforce and had seen a 50 whole time equivalent (WTE) reduction between April and June 2025. • A month 12 comparison was displayed, highlighting growth areas such as secondary care medicines and prescribing. • A delivery of £28.6m in green and amber savings schemes, with £7.8m worth of schemes remaining in the red pipeline. • There was no slippage against green and amber schemes. • CAV UHB made considerable progress compared to last year. The CC noted the savings deficit remained the same and were still working on filling the gap. The DDF explained that the discussion about moving red pipeline schemes to amber and green was a weekly conversation at the Senior Leadership Team (SLT), chaired by the Chief Executive. He emphasized the need to set hard dates and ensure these schemes were translated into deliverable amber and green schemes to provide confidence and assurance of delivery. The UHB Chair noted that for several years CAV UHB have been saying the need to get ahead of the financial planning curve but have yet to achieve it and still end up in reactive mode each year. He informed colleagues that he is arranging a session in the board development meeting in August to discuss this very topic, aiming to understand what needs to be done differently to get savings plans in place well in advance of the financial year. The DDF confirmed they would include a forecast for the cash position and will track it graphically monthly moving forward. He also stated that they continue to deliver against the public sector payments compliance target, achieving 95.8% at the end of June. **Action - Adam to provide an interim update to the committee on operational pressures, actions, and Plan B before the next formal meeting** **Action - Andrew to provide a monthly cash position graph, including forecast, in future reports.** **The Finance and Performance Committee resolved that:** **a)** The reported year to date overspend of £15.216m and the reduction in the forecast deficit from £58.2m to £56.2m was noted. b) The month 3 operational overspend against plan of £0.314m and the £0.844m savings deficit was noted c) The progress against the savings target, with £28.624m (89.5%) of green and amber schemes identified at Month 3 against the revised £32m target was noted **d)** The delivery of the forecast was also predicated on the confirmation of all expected income streams was noted.	
FPC 23/07/2.2	**Operational Performance Update** The DOPP presented on the Operational Performance Update and highlighted the following points: • **Urgent & Emergency Care** • Attendances slightly reduced in June but remain higher than winter levels. • Admission rate increased to 15.6%.	

- Continued struggles with 12-hour waits and one-hour ambulance delays; June was another difficult month.
- 24-hour breaches reached 34, the highest in a long time.
- Other health boards are improving ambulance handover, but Cardiff faces specific challenges.
- Discharge volumes are a key issue; a "reset week" is underway to focus on improving urgent and emergency care pathways.
- **Out of Hospital & Community Care**
- Significant activity in primary and community care.
- Progress against GP access standards and community prescribing, but more work needed to integrate community care and increase weekend nursing capacity.
- **Hospital Flow & Discharge**
- Stroke and hip fracture performance improved slightly; capacity is ring-fenced and closely managed.
- Pathway care delays increased in June, mainly due to reduced discharge volumes.
- **Planned Care**
- Single cancer pathway performance improved from 59.5% to 69.5%.
- Long-waiting patients (>2 years) reduced by over 600; commitment to reduce further by end of Q2.
- 8-week diagnostic position improved by about 1,000 patients, especially in non-obstetric ultrasound.
- Some risk remains in endoscopy, but plans are in place.
- **Primary, Community, and Dental Care**
- Increased patient numbers in pharmacy, dental, and community services.
- Dental contract changes are being implemented, confidence in meeting annual targets.
- District nursing capacity up from last year but still below Welsh Government standards.
- **Mental Health**
- Children's services: good performance on assessment and intervention times; neurodevelopment waiting times remain a challenge.
- Adult services: stabilisation in 28-day assessments, but capacity and referral rates are still challenging.
- Four key reasons for increased adult referrals: high demand for neurodiversity assessments, steady post-COVID increase, population growth (especially in certain clusters), and temporary increase after service model changes.
- **Productivity & Efficiency**
- Outpatient DNA rates remain high; targeted actions and overbooking were being implemented.
- Endoscopy room utilisation was high but can improve further.
- Theatre utilisation improved slightly; more detail in enabling actions update.
- Length of stay in medicine has not reduced as planned, impacting both operational and financial targets.
- **General Summary**
- CAV UHB need to continue to focus on reducing length of stay and improving flow to support both operational and financial objectives.

The UHB Chair asked about discharge delays, specifically requesting an explanation for why the committee continues to struggle with pathway of care delays, noting they remain around the 150–160 mark and do not seem to be decreasing despite ongoing efforts. He asked for this to be included in the next update or commented on during the meeting.

The DOPP responded that good progress had been made in pathway of care delays, with numbers coming down from previous highs, but acknowledged the figure had jumped back up slightly this month and generally plateaued. He noted CAV UHB's performance was slightly better than the rest of NHS Wales, but most current challenges were internal and were being addressed during the reset week.

The UHB VC stated it would be useful to know where the patients with pathway of care delays are located and reside, and expressed interest in seeing if they are from Cardiff, the Vale of Glamorgan, or other areas of Wales.

The UHB Chair wanted to note the overall picture of diagnostics hadn't moved and secondly, we were promised the use of a facility at CTT and asked what progress was being made?

The DOPP confirmed that issues with equipment failure, particularly around CT and MRI, had resolved, so positions in those areas had not worsened and improvement trajectories would be

	delivered. He noted the overall number had reduced significantly. Regarding the endoscopy plan with Cwm Taf, he explained it was due to go live but faced challenges with patient booking—originally Cwm Taf was to book patients, but this did not happen, so CAV UHB was now using temporary administrative services, which were approved last week. The IMLA asked for clarification regarding the general dental service, specifically whether the reported 15% of the contract delivered so far was a month 3 position, and if continuing at that level would mean only achieving 60% of the contract across the year. The DOPP confirmed that the dental activity data is always a month behind, and the 15% figure is for the total dental contract. The IMLA asked if there is a risk that some children on the neurodevelopment service waiting list will become adults while waiting to be treated, and what happens at that point. The DOPP responded that there was a risk some children become adults while waiting, and the neurodevelopment teams have been working between adults and children's services on transition and what happens to patients on the waiting list. Adam said they would need to go back to the team for the specifics of what happens when a patient turns over to adulthood and would come back with that information. The UHB Chair stated that the Minister for Mental Health, Sarah Murphy, has recently issued a letter directing more money towards reducing the waiting lists for neuro divergent diagnosis. **Action - The DOPP agreed to include a detailed update on pathway of care delays, including patient locations, in the next meeting during the Operational Performance Report discussion** **Action - The DOPP to clarify the process for children waiting three years for neurodevelopment assessment who transition to adulthood, ensuring they do not go to the bottom of the adult waiting list.** **Action - The DOPP to provide regular updates on progress against the 104-week wait reduction trajectory and the 34,000 additional appointments plan.** **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 23/07/2.3	**Quarterly Annual Plan Update** The HSP gave a quarterly update on the Annual Plan and highlighted the following: • The report summarized highlights and achievements aligned to strategic portfolios ar "brilliant basics" priorities set out for the year. • Focused on strategic initiatives and non-KPI milestones that may not be visible in oth reporting mechanisms but are important for tracking progress. • Positive progress was highlighted in areas such as workforce ambitions, establishing a integrated community care system, community vaccination programs, digital foundation partnership arrangements, and the clinical services plan. • The report included a summary of key numbers for the quarter, such as ministerial delive expectations and finance position, with detailed data available in the integrated performan and finance reports. • Part of the report outlined common strategic challenges, including implementation delay external dependencies (e.g., national programs, capital funding), and complex governan for regional initiatives. • The report was based on a detailed action tracker with 200 actions, RAG-rated quarterly, ar tracked through the senior leadership team, focusing on troubleshooting red and amb actions. • A narrative summary was proposed as the most effective way to demonstrate progress committee level and ensure effective assurance on the plan. The IMLA looked for clarity on the head count. It said the workforce had reduced by 81 WTE but th report from the DDF stated a different figure. She added that each committee needs to recei consistent data. The HSP would clarify on this figure with workforce colleagues and report back to the committee.	

	The UHB Chair he endorsed the IMLA comments as we need to ensure we are measuring the rig things here. Every time we ask about the headcount, a different answer is given. It is important understand how, what, why and when. He added that the report was helpful, and it is important whe this committee stands. The UHB VC commented on the importance of measurement tools and the development methodologies to support benefits realisation, urging that this be dealt with rigorously. He suggeste that if benefits (such as reductions in expenditure) were not being realised, the organization shou be proactive in stopping some of these schemes, noting a tendency to start new initiatives but not stop them. He emphasized that more work is needed to ensure clarity on what the benefits are ar when they have been realised. **Action – The DDF & the HSP to clarify & align workforce reduction figures for consiste reporting.** **The Committee resolved that:** a) The progress highlighted in the Q1 Annual Plan Report was noted.	
FPC 23/07/2.4	**Enabling Actions & Ministerial AG** The DOPP highlighted the following points: • Welsh Government set several enabling actions, and the Ministerial Advisory Group (MAG) produced recommendations for HB's and government, published in April. • Many actions and recommendations overlap or are similar, and some are already part of the health board's established performance reporting (e.g., ambulance handover). • Adam combined enabling actions and MAG recommendations into one slide deck, themed by section, to avoid duplication and make reporting clearer. Each recommendation is linked to one or more measures, showing the standard, baseline, current performance, and a RAG rating (red, amber, green). • Red means the standard is breached, amber means it's breached but there's still time to deliver, and green means it's being delivered. • Adam noted there is no central guidance yet on best practice for measuring/reporting most actions, though Welsh Government is setting up a dashboard for this. The report and measures may mature as more advice is received. • For urgent and emergency care, most measures are not being met, but the board is engaged in delivering recommendations and has good representation at national groups. More work is needed to reduce attendances, ambulance handover delays, and improve hospital flow. • In planned care, most actions/recommendations are for Q2 or later, but progress is being made (e.g., SOS and PIFU, direct listing of cataracts from August). • Theatre actions and productivity/efficiency aims are being addressed, with improvements in cataract procedures since moving to UHL. • For improving value, there is good progress in cancer pathways (e.g., straight to test), digital initiatives (NHS app, new maternity software), but some data validation and collection challenges remain. • On workforce productivity, there is an overall reduction in agency spend and improved consultant job planning rates. Adam noted two corrections: agency numbers do not include medical agency (to be added), and sickness figures are in-month, not cumulative (to be corrected). • Finance slide shows progress in non-pay and medicines management, but continued pressure in CHC budgets and ongoing estates rationalisation. Adam emphasized the need for consistent, useful information across reports. • Adam concluded by inviting questions and feedback, noting the report will evolve and is used internally for executive and clinical board reviews, and will be submitted to Welsh Government as part of national reporting. The CC asked the DOPP who sees the enabling actions and MAG update report as useful, specifically whether clinical board directors find it useful and if it is shared elsewhere in the organization. The DOPP responded that it was used in executive clinical board reviews, planned care programme meetings, and will be submitted to WG, though the exact department is unclear. He added that a quarterly update on MAG would be given to the CAV UHB Board.	

	Action – The DOPP to update the enabling actions and MAG report with medical agency numbers and correct sickness figures in future iterations during the enabling actions and MAG update discussion. **The Committee resolved that:** a) The progress and challenges in relation to delivering against the Ministerial Enabling Actions and the Ministerial Advisory Group on Performance and Productivity Recommendations was noted.	
FPC 23/07/2.5	**Board Assurance Framework** The DCG updated on the Board Assurance Framework and highlighted the following: • The Board Assurance Framework (BAF) was used to track progress against strategy and that the board requested it be reviewed in relevant committees for more detailed discussion. • It was proposed to bring the BAF to the F&P every other month, aligned with board meetings, and rotating the focus between finance (long-term financial plan), decarbonisation/climate (sustainability risk), and R&D (acting for the future/future generations portfolio). • This approach would ensure each topic area receives adequate attention and invited questions or discussion on the proposal. The CC expected to see this periodically and it is good to see this on a regular basis. The EDPH endorse the position in ensuring it comes to a committee to achieve good airtime. The DDF noted this was around the longer term strategic plans. We need to ensure we are ahead of the game. **The Committee resolved that:** a) The Board Assurance Framework was noted.	
FPC 23/07/3.1	**Business Cases: TRAMs Case** The DDF highlighted: • The purpose is to create a medicines preparation unit for SE Wales, consolidating manufacturing units for efficiency. • The committee is asked to approve progression to full business case stage and onward approval to board, with a £19.1m WG capital funding requirement. • The Pre-Business Case (PBC) was originally developed in 2021, so the project has been ongoing for some time. • Total revenue savings identified are £5.2m, to be shared among regional providers, with the exact shares still under discussion. • Several caveats needed resolution before progressing to Full Business Case (FBC): application of TUPE for staff transfers, the clinical trials position, and staffing models, to ensure Cardiff and Vale receives its fair share of savings. • The case has been reviewed by the Value Benefits Realisation Group and Senior Leadership Team, both supportive but requiring the caveats to be addressed before FBC. The CC asked about the timescale for the full business case (FBC) to go to Welsh Government, seeking clarification on when it would be expected. The DDF responded that he was not cited on the exact timeline for the FBC but recommended that all caveats be addressed before the FBC is written. The IMTU agreed that the TRaMS proposal made perfect sense for long-term savings and to avoid duplication. He asked if CAV UHB has considered what happens if staff decide not to transfer under TUPE, specifically whether there were suitable redeployment opportunities for them. He raised the concern that if redeployment was not possible, redundancies may be necessary, which could cost CAV UHB money, and questioned who would be responsible for paying those redundancy costs. The DDF confirmed that if the staff were CAV UHB employees, the responsibility for redundancy costs would fall to the Health Board, and noted this detail would need to be confirmed with	

	People and Culture colleagues. He added that this level of detail was unlikely to be included at the OBC stage. The DCG & DOPP confirmed that a letter has been sent to shared services to clarify this point, and the FBC would need to specifically address it. The CC noted the OBC was recommended to go to Board next week. **Action – The DDF to confirm redundancy details with People & Culture Colleagues.** **The Committee resolved that:** a) The TRAMs outline business case was approved	
FPC 23/07/3.2	**Business Cases: Park View Case** The DDF highlighted the following points: • The Parkview Well-being Hub PBC was endorsed by Welsh Government in August 2019, and the FBC now seeks approval for onward submission to the Board. The new facility will replace the Parkview Health Centre, which had a major water leak, with services temporarily relocated to other sites. • The capital funding requirement is £36.8m, with an increased revenue requirement of £624k for the Health Board, mainly due to estates running costs and carbon neutrality requirements. • The challenge of agreeing to cases with a revenue tail given the current deficit was highlighted, and that work was ongoing with Estates and Clinical Board colleagues to mitigate these costs. If not fully mitigated, the first call on allocation uplift would be to cover these revenue costs. • The Value Benefits Realisation Group and SLT supported progressing the case due to its urgency and necessity for Ely, despite the affordability challenge. The CC asked if, given the additional costs in supporting a regional facility, a case could be made to help support with those costs, and whether such a case had been clearly made for additional revenue support. He questioned if these costs could be supported as an additional revenue item or if the Health Board would have to manage them as is. The DDF responded that it was highly unlikely any additional revenue costs linked to this case would be supported by WG, and that it would be CAV UHB's responsibility to manage and offset these costs if the project proceeds. The UHB VC stated that, having personally visited some of the facilities in this part of the Health Board, it is probably bordering on imperative to support this development. They noted excellent work is being done despite the current facilities and emphasized the need to map out the consequences of not proceeding, as these could have significant revenue implications. Ceri questioned whether the research into revenue implications had been fully undertaken in this context. The DDF explained the trade off between in year affordability and future value and benefits is difficult given the current financial position and climate. The IMLA questioned whether the proposal was ready to go to the Board, given the real issue around affordability and underlying pressures. She highlighted that the impact of not proceeding would be significant for patients and residents, and there is also a financial impact of not doing this. Susan noted that, because mitigations are not in place, it would be helpful to address this. She then asked if there was an imperative in terms of timelines for bringing this to the Board. The HSP confirmed there was an imperative and that is why we aimed to get it into July Board. The CC highlighted the need to see the full business case to share via email. **Action: The Park View Hub Business Case to be added to the forward plan for Finance & Performance Committee.** **The Committee resolved that:** a) The Park View Business case would need discussion and approval outside of this committee.	

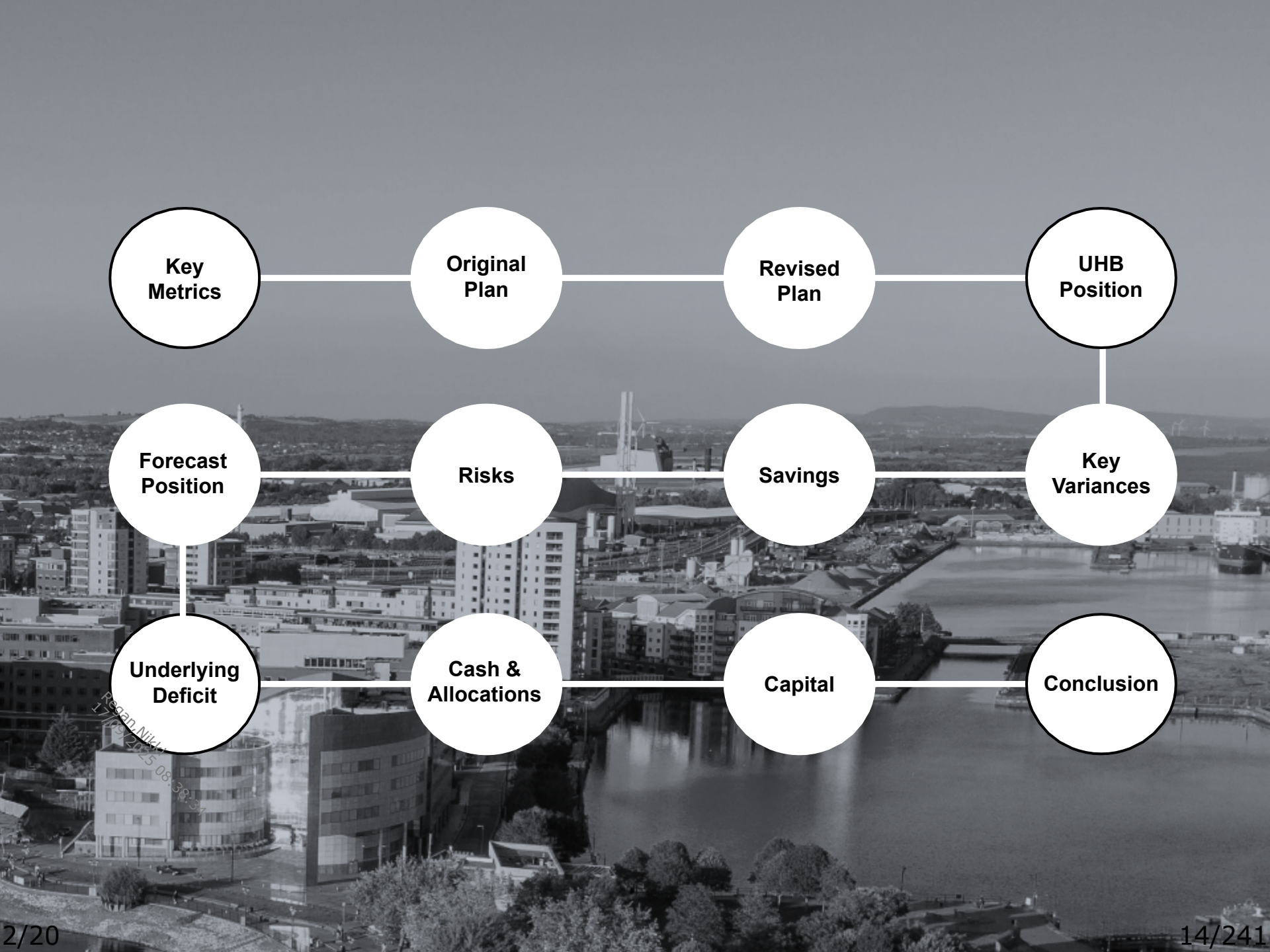
FPC 23/07/4.1	**Monthly Monitoring Return – Month 2** The monthly monitoring return was noted. **The Finance and Performance Committee resolved:** a) The extracts from the UHBs Monthly Financial Monitoring Returns for Month 2 was noted	
FPC 23/07/5.1	**Any Other Business** No further business was raised.	
FPC 18/06/013	To note the date, time and venue of the next Committee meeting: **Wednesday 17th September 2025 via MS Teams**	

Public Action Log
Finance & Performance Committee
(Updated for the meeting being held 17 September 2025)

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE DUE	STATUS/COMMENTS
FPC 23/07/2.3	Workforce Reduction Figures	Andrew and Ash to clarify and align workforce reduction figures for consistent reporting	Andrew Gough / Ash O'Callaghan		**COMPLETE** Andrew to update the Committee during finance update.
FPC 23/07/2.1	Operational Pressures	Adam to provide an interim update to the committee on operational pressures, actions, and Plan B before the next formal meeting	Adam Wright		**COMPLETE** Adam to update the Committee during finance update.
FPC 23/07/2.2	Pathway of Care Delays	Adam agreed to include a detailed update on pathway of care delays, including patient locations, in the next meeting during the Operational Performance Report discussion	Adam Wright		**COMPLETE** Adam to update the Committee during Operational update.
FPC 23/07/2.2	Neurodevelopment – Childrens wait list	Adam to clarify the process for children waiting three years for neurodevelopment assessment who transition to adulthood, ensuring they do not go to the bottom of the adult waiting list.	Adam Wright		**COMPLETE** Adam to update the Committee during Operational update.
FPC 23/07/2.1	Cash Position	Andrew to provide a monthly cash position graph, including forecast, in future reports.	Andrew Gough		**COMPLETE** Andrew to update the Committee during finance update.
FPC 23/07/2.2	104 week wait	Adam to provide regular updates on progress against the 104-week wait reduction trajectory and the 34,000 additional appointments plan.	Adam Wright		**COMPLETE** Adam to update the Committee during Operational update.
FPC 23/07/2.4	Enabling Actions and MAG Report	Adam to update the enabling actions and MAG report with medical agency numbers and correct sickness	Adam Wright		**COMPLETE**

		figures in future iterations during the enabling actions and MAG update discussion.			Adam to update the Committee during Operational update.
FPC 23/07/3.2	Park View Hub – Business Case	Matt and John agreed to arrange a single-item meeting for committee members to review the full business case for the Parkview Well-being Hub before Board approval during the Parkview Well-being Hub Full Business Case discussion	Matt Phillips / John Union		**COMPLETE** This has been added to the forward plan for 17.09.2025
ACTIONS TO BE REFERRED TO BOARD / COMMITTEES:					

CARDIFF & VALE UHB
FINANCE REPORT – MONTH 5



The table below highlights the UHB's key financial metrics and performance against them :

Measure	Description	RAG	Trend	Target	Time Period
Deliver 2025/26 Deficit Target Control Total	The Revised Draft Annual Plan includes a forecast £56.2m deficit - £47.1m over the control total target of £9.1m.	R	"	9.1m	M5 2025/26
Return to financial balance and approved IMTP status	£56.2m underlying deficit by end of 2025/26 financial year. Currently reporting savings gap after Month 5.	R	"	£56.2m	M5 2025/26
Management of operational budget pressures	Failure to adequately manage budget pressures. This is the responsibility of the primary budget holders. £2.913m operational deficit reported at Month 5.	A	#	Operational Spend to be maintained within Budgets	M5 2025/26
Delivery of recurrent £32.0m savings target	£28.894m Green and Amber schemes identified at Month 5, of which £23.520m were recurrent.	A	#	£32.0m	M5 2025/26
Remain within Cash Limit	The UHB will require cash support from WG for the 25/26 planned deficit of £56.2m along with likely movements in working capital from the 2024/25 balance sheet.	A	"	To remain within Cash Limit	M5 2025/26

The UHB's Financial Plan in 2025/26 reflected the following key components:

Planning Assumptions	(£m)
Brought Forward Underlying Deficit	59.900
2025/26 Demand/Cost Growth/Improvement	51.100
Draft Deficit	**111.000**
Additional Allocations	(22.768)
Savings Plans	(30.000)
Initial Planned Deficit	**58.233**
Additional In Year Savings Plans	(2.000)
Revised Planned Deficit	**56.233**

The initial planned deficit of £58.2m was noted by the UHB for submission to Welsh Government (WG) and the draft plan was submitted at the end of March 2025. Following the submission of the plan, Welsh Government asked the UHB to detail further actions to reduce the forecast deficit of £58.2m. In response, the UHB confirmed that progress in the identification of savings provided the UHB with sufficient assurance to increase planned savings delivery by £2m which in turn has reduced the forecast 2025/26 deficit position to £56.2 million.

The submitted plan projects a deficit for the financial year and therefore a failure of the UHB's statutory requirement to deliver a balanced financial plan over a 3-year rolling period. This also prevents Ministerial approval of the plan.

At Month 5, the UHB is reporting a year to date overspend of £27.809m.

	Plan PTD (£m)	PTD (£m)	PTD Variance to Plan (£m)	Plan YTD (£m)	YTD (£m)	YTD Variance to Plan (£m)	Plan	Forecast	Forecast Variance to Plan (£m)
Draft Plan	7,179	7,179	0	35,017	35,017	0	88,233	88,233	0
Quality Efficiency Improvement Plans - Savings	(2,491)	(2,528)	(37)	(11,587)	(10,121)	1,466	(32,000)	(28,482)	3,106
Operational Variance	0	1,987	1,987	0	2,913	2,913	0	0	0
Clinical/ Service Board Variance	**4,688**	**6,638**	**1,950**	**23,430**	**27,809**	**4,379**	**56,233**	**59,751**	**3,106**

In-month, the financial plan components moved as follows:

- Planning Deficit **£23.430**
- Savings Programme deficit of **£1.466m**
- Operational Position deficit **£2.913m.**

The overall financial position at month 5 was a £27.809m deficit

At month 5, there was a shortfall of £3.106m against the revised £32.0m savings programme target. This will lead to a further £3.106m overspend against the planned £56.2m deficit if further schemes are not identified and delivered as the year progresses.

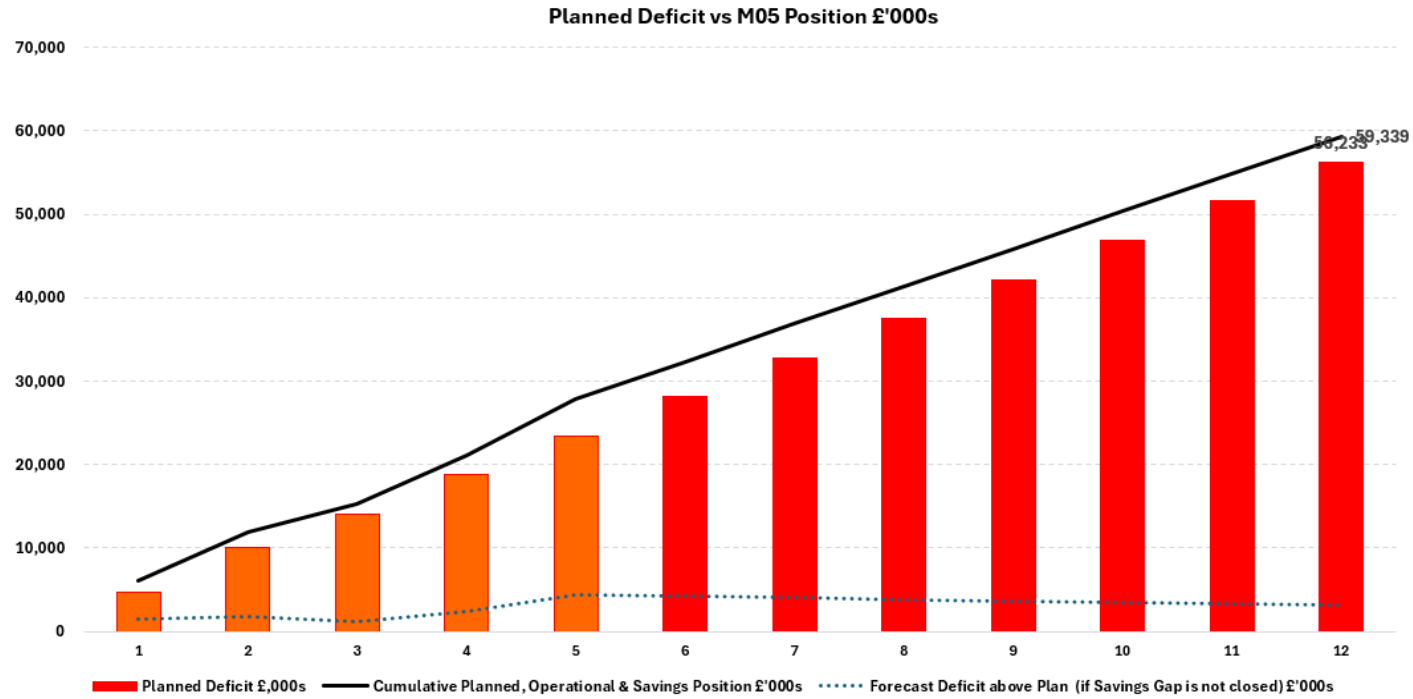
It is expected that the unachieved CRP gap and operational pressures at month 5 will be managed and mitigated as the year progresses and that the UHB will deliver its planned deficit position of £56.233m.

The following actions have been identified to halt and recover the deteriorating operational position.

Board Approved - A full vacancy freeze from 1st August

- The UHB has operated an enhanced centralised vacancy scrutiny process for over 6 months. This approach has stabilised the growth of the workforce, and between February and June 2025 the overall number of staff in post has reduced by 79 WTE.
- Based on current turnover, a full vacancy freeze (with requests to advertise critical posts only approved in exceptional circumstances) would likely equate to 350 staff leaving by end of the year, that we would not replace. This could release up to £4.2 million in year.
- Only utilising additional winter capacity if absolutely necessary (£1.6m in plan)

The graph below shows the reported Month 5 position against the UHB's planned deficit of £56.233m



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Planned Deficit £,000s	4,686	10,096	14,058	18,744	23,430	28,117	32,803	37,489	42,175	46,861	51,547	56,233
Cumulative Planned, Operational & Savings Position £'000s	6,096	11,899	15,216	21,172	27,809	32,313	36,818	41,322	45,826	50,330	54,835	59,339
Forecast Deficit above Plan (if Savings Gap is not closed) £'000s	1,410	1,803	1,158	2,428	4,379	4,197	4,015	3,833	3,651	3,470	3,288	3,106
24/25 deficit outturn of £27.7m	6,096	11,899	15,216	20,149	20,149	20,993	22,117	23,241	24,365	25,489	26,613	27,737

The monthly planned deficit is evenly phased through the year in line with Welsh Government Monthly Monitoring Return Guidance. The level of savings forecast each month increases as the year progresses.

At month 5 , there was a shortfall of £3.106m against the £32.0m savings programme target which includes an additional target of £2m on top of the initial target. This will lead to a further £3.106m overspend against the planned £56.2m deficit if no further schemes are identified and delivered as the year progresses. Clinical Boards are being pressed to find additional savings to reduce the gap in year. The expectation is that the monthly deficit will reduce as the UHB successfully identifies and delivers further savings in year.

In addition, further actions need to be identified and implemented to halt and recover the deteriorating operational position.

The tables below summarises the in-month and cumulative performance of the UHB by its major expenditure groups:

	Income	Pay	Non Pay	Total
In-Month	**£'000s**	**£'000s**	**£'000s**	**£'000s**
Budget	(52,846)	98,131	86,819	**132,105**
(Income)/Expenditure	(52,781)	98,755	92,769	**138,743**
Variance	**65**	**624**	**5,949**	**6,638**
Cumulative	**£'000s**	**£'000s**	**£'000s**	**£'000s**
Budget	(261,707)	435,282	442,109	**615,685**
(Income)/Expenditure	(261,789)	435,407	469,877	**643,495**
Variance	**(83)**	**125**	**27,768**	**27,809**

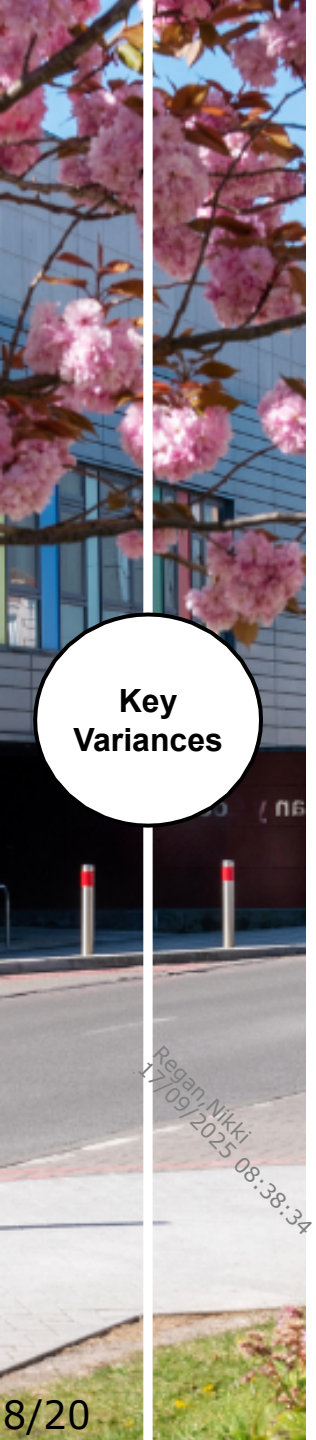
A number of operational pressures unfolded in month 5 which in turn have been offset by pay vacancies and a slowdown in prescribing growth. The following operational issues were reported in month 5:

- Income – Specialist services underperformance. There is reported underperformance in cardiac services where the UHB continues to reviewing activity against the previous year's delivery. Underperformance against out of area critical care capacity is improve as the proportion of Cardiff and Vale patients decreases. The shortfall of income in retail outlets is being reviewed by site.

- Pay – vacancies in Clinical Diagnostics and Therapies, Estates, Executive functions & PCIC along with enhanced scrutiny around variable pay has offset pressures against medical staff where additional costs are being incurred to cover vacancies, Less Than Full Time (LTFT) posts and sickness. The in month deterioration is in part due to a significant amount of banding arrears paid in relation to resident doctors in month. The UHB' s monthly monitoring return to Welsh Government has identified the cost of the 2025/26 pay award which was actioned in and expects Welsh Government to fully cover the cost of the award.

- Non Pay – Continuing pressures are reported against Mental Health Out of Area (OOA) referrals where numbers have reduced but the acuity remains high. The shortfall in national funding for the 2025/26 NI increase is reported against non pay at £0.894m for the year to date (£2.145m full year). £24.664m of underlying deficit was included in non pay at month 5.

£23.430m of the deficit at month 5, is due to the £56.233m revised planning deficit with £4.379m of the deficit relating to the shortfall against the savings plan and operational pressures.



The tables below summarises the cumulative position of the UHB by business unit:

Business Unit	Deficit Control Total/ Plan (£k)	Savings (£k)	Operational (£k)	Total (£k)	Variance to Plan (£k)
Clinical Diagnostics & Therapeutics	(106)	148	(67)	**(25)**	80
Children & Women	2,020	244	(323)	**1,941**	(79)
Capital, Estates & Facilities	29	74	(247)	**(145)**	(174)
Executives	(609)	85	(288)	**(812)**	(203)
Genomics	0	0	(39)	**(39)**	(39)
Medicine	6,033	43	296	**6,372**	340
Mental Health	2,929	(158)	744	**3,515**	586
Primary, Community & Intermediate Care	4,378	396	920	**5,693**	1,316
Specialist	2,054	195	1,122	**3,371**	1,317
Surgery	1,822	440	(18)	**2,244**	422
Sub-Total (Delegated Position)	**18,550**	**1,466**	**2,100**	**22,116**	**3,566**
Central Budgets	(3,203)	0	647	**(2,556)**	647
Commissioning	8,083	0	166	**8,249**	166
Sub Total (Non-Delegated Position)	**4,880**	**0**	**813**	**5,693**	**813**
Sub-Total Surplus/ Deficit	**23,430**	**1,466**	**2,913**	**27,809**	**4,379**

The table/chart below summarises the key 2025/26 Operational pressures as at month 5:

Operational Pressure	Operational Variance YTD £'000s	Operational Variance Forecast £'000s
Mental Health Out Of Area Placements (OOA)	1,200	1,003
Specialist Services Activity Related Underperformance	1,600	0
Employers NI (ENIC) Funding Gap	894	2,145
JCC Forecast Outurn Growth	200	1,036
Medical Staff Banding Arrears	300	300
GP Out of Hours pay resolution	1,000	1,000
Prescribing & Childrens CHC Growth	200	0
Pay Vacancies & other mitigating actions to be agreed	(1,015)	(5,484)
Sub-Total Surplus/ Deficit	**4,379**	**0**

The following actions have been identified to halt and recover the deteriorating operational position.

Board Approved - A full vacancy freeze from 1st August

- The UHB has operated an enhanced centralised vacancy scrutiny process for over 6 months. This approach has stabilised the growth of the workforce, and between February and June 2025 the overall number of staff in post has reduced by 79 WTE.
- Based on current turnover, a full vacancy freeze (with requests to advertise critical posts only approved in exceptional circumstances) would likely equate to 350 staff leaving by end of the year, that we would not replace. This could release up to £4.2 million in year.
- Only utilising additional winter capacity if absolutely necessary (£1.6m in plan)

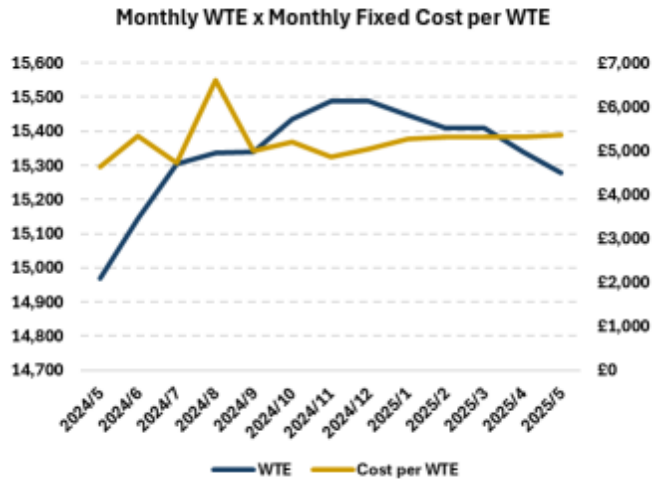
The table/chart below summarise the 2024/25 & 2025/26 Pay expenditure run rates at month 5 for all staffing groups (split by fixed and variable expenditure) :

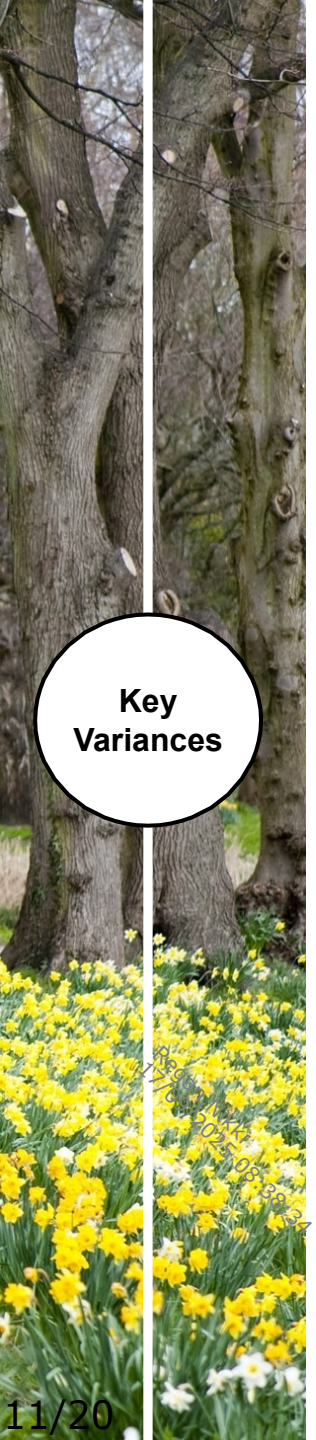
Staffing Group	2024/25 YTD (£m)	2025/26 YTD (£m)	2025/26 vs 2024/25 Growth (£m)	2025/26 vs 2024/25 Growth (%)
Additional Clinical Services	14,421	16,206	**1,785**	**12.4%**
Management, Admin & Clerical	46,974	53,612	**6,638**	**14.1%**
Medical and Dental	98,063	120,915	**22,853**	**23.3%**
Nursing (Registered)	106,832	123,462	**16,630**	**15.6%**
Nursing (Unregistered)	34,813	36,604	**1,791**	**5.1%**
Other Staff Groups	57,437	64,500	**7,063**	**12.3%**
Scientific, Prof & Technical	19,069	20,108	**1,039**	**5.4%**
Total	**377,608**	**435,407**	**57,799**	**15.3%**

Increased pay expenditure since April 2024 is supported by an increase in substantive headcount/WTE.

The retrospective 2023/24 medical pay awards , the 2024/24 pay awards, the increase to National Insurance Employers contributions and 2025/26 Pay Awards account for 13.6% of the increase in pay costs.

The chart (right) reports substantive WTE by month – and indicates a 309 WTE increase across the UHB since August 2024 . The estimated annual cost of the additional head count is £19.861m at average pay rates. The monthly fixed pay cost per WTE has increased by 10.91% across the same period from £4,627 to £5..348 (primarily due to pay awards).Month 12 pay costs have been adjusted to exclude the annual notional pension payment funded directly by Welsh Government. A reduction of 168 wte staff is reported between April 2025 and August 2025.





Key Variances

Non Pay expenditure was identified as a primary driver behind the UHB's deficit financial position in 2024/25. The table below reports year-to-date growth versus 2024/25 and the chart below outlines the run rate for Non Pay expenditure.

Staffing Group	2024/25 YTD (£m)	2025/26 YTD (£m)	Growth (£m)	Growth (%)
Clinical Services & Supplies	52,338	53,797	**1,459**	**2.8%**
Continuing Healthcare	43,706	49,588	**5,881**	**13.5%**
Drugs / Prescribing	105,560	111,162	**5,603**	**5.3%**
Establishment Expenses	5,752	5,629	**(123)**	**-2.1%**
General Supplies & Services	4,842	5,347	**505**	**10.4%**
Healthcare Provided Services	110,756	120,376	**9,620**	**8.7%**
Other Non Pay	29,058	33,231	**4,173**	**14.4%**
Premises & Fixed Plant	21,816	21,704	**(113)**	**-0.5%**
Primary Care Contractors	63,477	69,043	**5,566**	**8.8%**
Total	**437,306**	**469,877**	**32,571**	**7.4%**

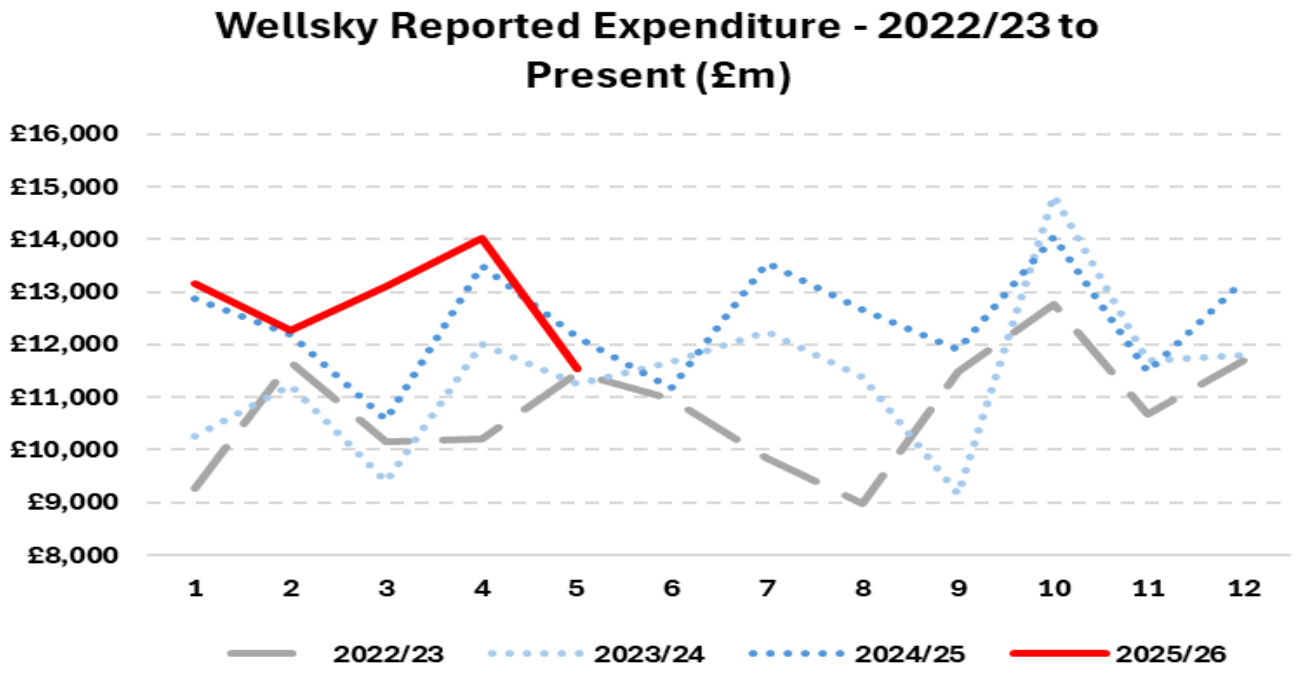
The UHB reported **£469.877m** of Non Pay expenditure for the year to Month 05 which is an increase of 7.4% on the same period in the previous year. The large part of the increase is driven by expenditure in the following areas:

- Secondary Care & GP Prescribing
- Primary Care contracts (including contractual uplifts)
- Price and demand in Continuing Healthcare (CHC)
- Additional Commissioning cost including Mental Health Out of area Placements and JCC under Healthcare Provided Services.

Drugs expenditure (both Primary & Secondary Care) remain a constant pressure for the UHB.

The Wellsky Dashboard collates secondary care drug data and reports the highest Month 1 -5 expenditure over the past 4 financial years **(£64.1m).** 2024/25 reported £149.3m of expenditure vs £129.1m in 2022/23 further highlighting the rising costs in this expenditure area.

Finance are working closely with Pharmacy following the rollout of the Wellsky dashboard to clearly identify the drivers of growth and find mitigating actions to address them.



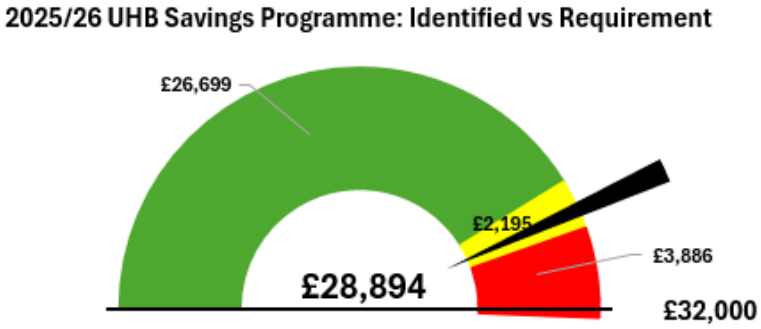
Savings

At the time of reporting , the UHB had identified £28.894m (90.2%) of green and amber savings to deliver against the revised £32.0m savings target. Red schemes of £3.886m were also identified and continue to be reviewed for progression to Green/Amber where possible.

Work to accelerate schemes since the end of August has increased the level of green and amber schemes identified from £28.482m to £28.894m.

The reported gap of £3.106m in identified savings incorporates red schemes and the unidentified balance. Red schemes are not included in accordance with the instruction from Welsh Government that red schemes are excluded from the Monthly Monitoring Returns savings tables.

£23.520m of recurrent were identified leaving a gap of £8.480m against the £32m recurrent target.



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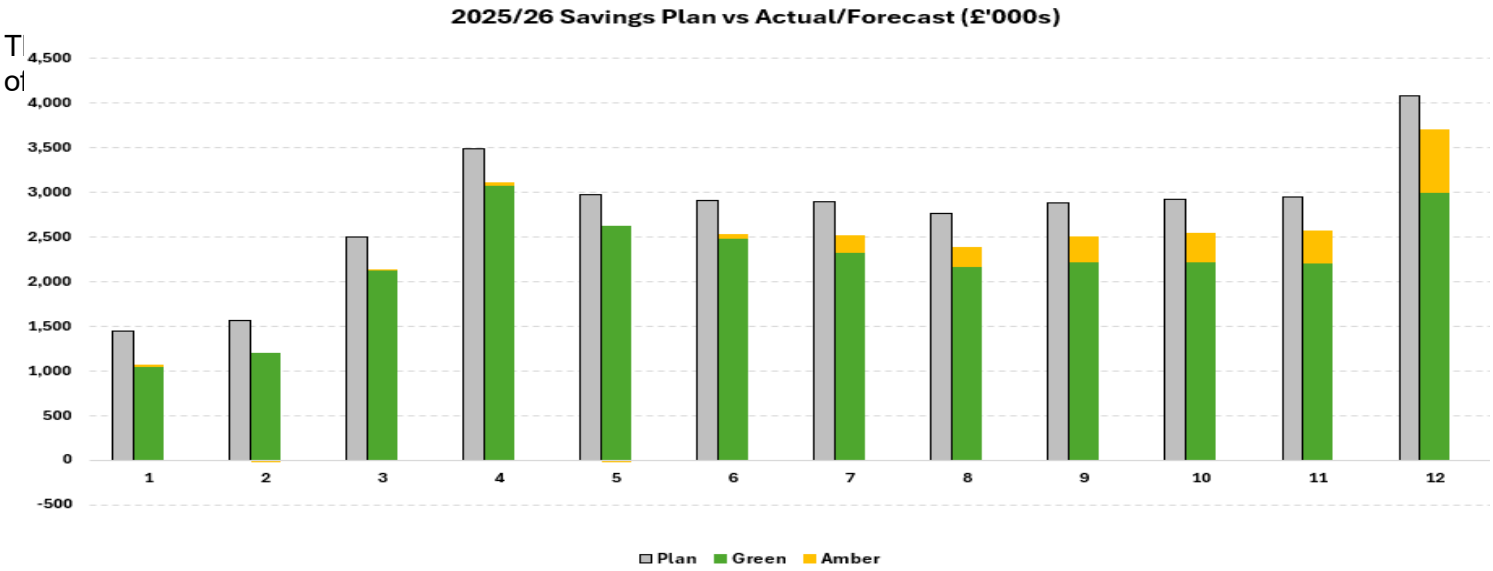
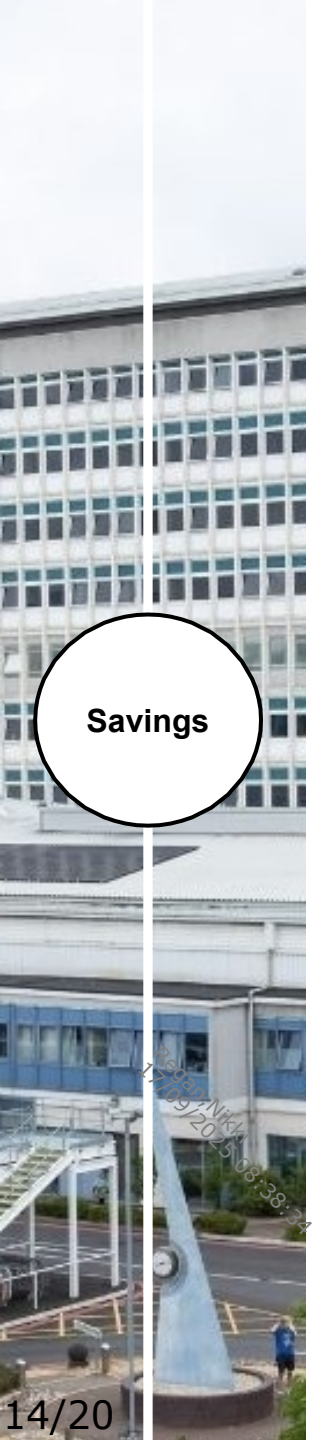




Further detail of the progress by Clinical Boards and Improvement Themes is provided below:

Business Unit	Target (£m)	Green (£m)	Amber (£m)	Total (£m)
CD&T	-	1,220	0	**1,220**
Children & Women	-	1,803	30	**1,833**
Capital, Estates & Facilities	-	730	98	**828**
Executives	-	1,442	0	**1,442**
Genomics	-	0	0	**0**
Medicine	-	482	0	**482**
Mental Health	-	0	0	**0**
PCIC	-	1,281	60	**1,341**
Specialist	-	1,170	0	**1,170**
Surgery	-	544	44	**588**
Sub-Total (Grip & Control)	**10,000**	**8,672**	**232**	**8,904**
Medicines Management	3,500	3,514	410	**3,923**
Income Generation	1,000	1,770	615	**2,385**
Continuing Healthcare	2,000	726	130	**856**
Facilities and Estates / Service Reconfiguration	1,000	244	13	**257**
Value/Clinical Variation	0	194	23	**216**
Procurement	3,500	3,427	75	**3,502**
Workforce - Temporary Pay	5,500	2,913	0	**2,913**
Workforce Restructuring	5,500	5,239	698	**5,937**
Sub Total (Cost Improvement Themes)	**22,000**	**18,027**	**1,963**	**19,990**
Sub-Total Surplus/ Deficit	**32,000**	**26,699**	**2,195**	**28,894**

The key risk which feeds the UHB Corporate Risk Register is the failure of the UHB to deliver a breakeven position by 2025/26 year end with a current planned deficit of £9.1m and a forecast out-turn against the revised planned deficit of £56.2.m.

Below is a summary of UHB Corporate Risk Register at August 2025. Further information of the risks can be found in the risk register:

Finance Risk Title	Rating
The submitted IMTP has a planned deficit of £58.2m for 2025/26. Following submission of the initial plan the UHB has increase planned savings delivery by £2m which in turn has reduced the forecast 2025/26 deficit position to £56.2 million. This is £47.1m over and above the deficit target control total of £9.1m.	20
Ambition to improve on the £56.2m moving closer towards £9.1m	20
Achievement of capital statutory breakeven duty. The Health Board has a capital allocation, which it should not exceed on a three year rolling basis.	8
Failure to adequately manage budget pressures. This is the responsibility of the primary budget holders. If it was to occur it would compromise the achievement of the revenue statutory breakeven duty.	20
Failure to deliver the revised recurrent Cost Improvement Programme of £32m. Failure to deliver will impact on the Health Boards ability to deliver the revised planned 2025/26 deficit of £56.2m.	20
Failure to manage operational pressures to continue to deliver the revised £56.2m underlying deficit position (initial underlying deficit £59.9m).	20
2025-26 LTA framework in NHS Wales.	12
Remain within Cash limit.	20
Potential further All Wales Risk Pool liability of £7.530m	20
Potential additional cost of band 2 & 3 pay costs estimated at £8.310m	20

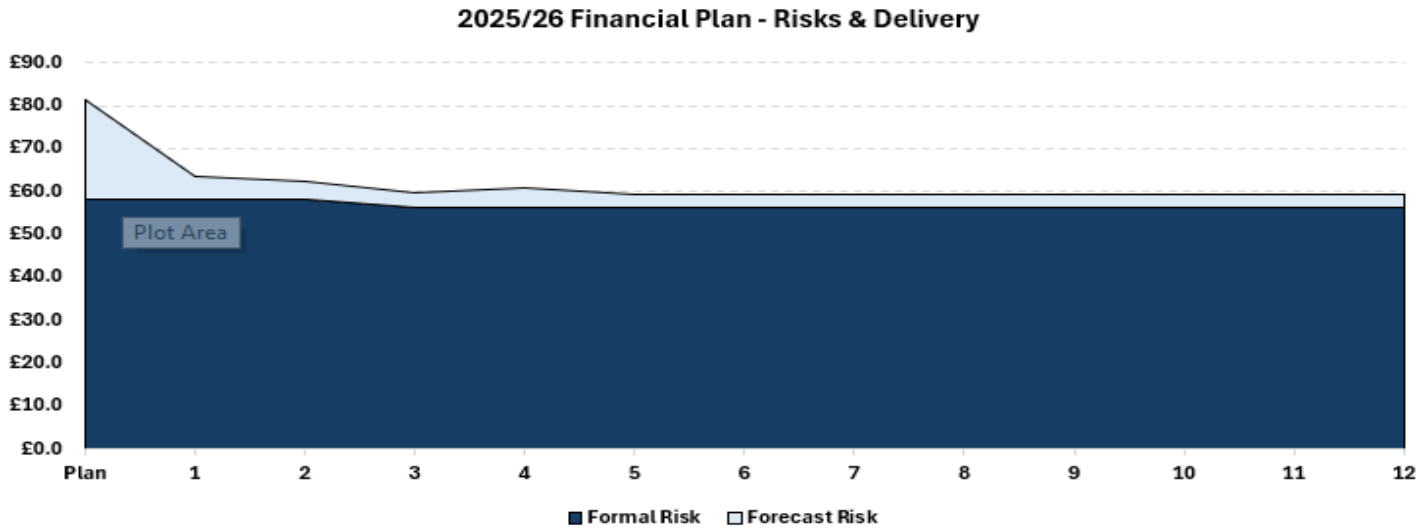
Forecast Position

When the UHB submitted its draft plan at the end of March 2025 there was an inherent risk in achieving the £58.233m planned deficit due to a £23m gap in identified savings against the £30m target. Since the submission of the plan the UHB has increased its savings target by £2m which in turn has reduced the planned deficit to £56.233m. The savings gap fell to £5.2m at the end of month 1 due to an acceleration in savings identified across the UHB. Following incorporation of the additional £2m savings target in June, the gap has fallen further to £3.106m at the time of reporting. The savings gap of £3.106m would lead to an annual deficit of £59.339m in 2025/26 if no further savings or mitigating actions are identified as the year progresses.

The **forecast risk** in the plan is currently assessed at £3.106m as illustrated below (reported in £m):

Item	Plan	1	2	3	4	5	6	7	8	9	10	11	12
Formal Forecast	58.20	58.20	58.20	56.20	56.20	56.20	56.20	56.20	56.20	56.20	56.20	56.20	56.20
WGadditional Funding	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Annual Savings Shortfall	**23.00**	**5.20**	**3.76**	**3.38**	**4.51**	**3.11**	**3.11**	**3.11**	**3.11**	**3.11**	**3.11**	**3.11**	**3.11**
Cumulative Savings Shortfall	0.00	0.43	0.15	0.32	0.60	(0.04)	0.23	0.23	0.23	0.23	0.23	0.23	0.23
Cumulative Operational Pressures	0.00	(0.01)	0.24	0.09	0.60	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Recovery Actions to be agreed	0.00	0.00	0.00	0.00	0.00	0.00	(0.42)	(0.42)	(0.42)	(0.42)	(0.42)	(0.42)	(0.42)
Forecast Risk (assuming recovery of £2.913m operational overspend)	**23.00**	**5.20**	**3.76**	**3.38**	**4.51**	**3.11**	**3.11**	**3.11**	**3.11**	**3.11**	**3.11**	**3.11**	**3.11**

The table below demonstrates the closure of forecast risk as the year has progressed.



Underlying Deficit

The UHB's underlying deficit (UHB) has deteriorated in recent years due to a combination of; underlying deficit brought forward; recurrent cost pressures (including inflation); under delivery of recurrent savings and demand-driven pressures in 2025/26.

The UHB has recently re-assessed its planning assumptions for the 2025/26 financial plan. The tables below summarise the projected underlying deficit of £58.2m.

Planning Assumption	£m
Underlying Deficit (ULD) brought forward	59.900
Demand and cost growth and unavoidable investments	51.100
Quality Improvement Programme - savings	(30.000)
Additional Recurrent Allocations	(22.767)
Planned Underlying Deficit (ULD) at end of 2025/26	58.233

After Month 5, the non-identification and/or non-delivery of recurrent savings presents a risk of further deterioration to the UHB's underlying deficit, if further recurrent savings plans are not identified and delivered in 2025/26 as illustrated below:

Planning Assumption	£m
Underlying Deficit (ULD) brought forward	59.900
Demand and cost growth and unavoidable investments	51.100
Quality Improvement Programme - savings	(32.000)
Additional Recurrent Allocations	(22.767)
Planned Underlying Deficit (ULD) at end of 2025/26	56.233
Shortfall against Recurrent Savings Target at month 5	8.480
Forecast Underlying Deficit (ULD) at end of 2025/26 without further identification of Savings & Actions	64.713

Further recurrent schemes are being developed to close the gap.

The closing cash balance at the end of August was £3.447m.

In due course, the UHB expects to seek Finance Committee and Board approval to request £56.2m strategic cash support from Welsh Government to cover the cash shortfall arising from the forecast deficit.

In addition, the UHB estimates that it requires £11m of working cash support to cover 2024/25 revenue and capital working balances paid in April 2025

The UHB monthly monitoring returns to Welsh Government identifies assumed cash allocations yet to confirmed. The value of unconfirmed drawing limit allocations at month 5 was £57.786m as outlined opposite. The outstanding confirmation of cash allocations is a cause for concern for the UHB, alongside the strategic and working cash requirement.

The table to the right summarises the potential for a £131.0m shortfall at year end before outstanding cash allocations and strategic support are confirmed by Welsh Government.

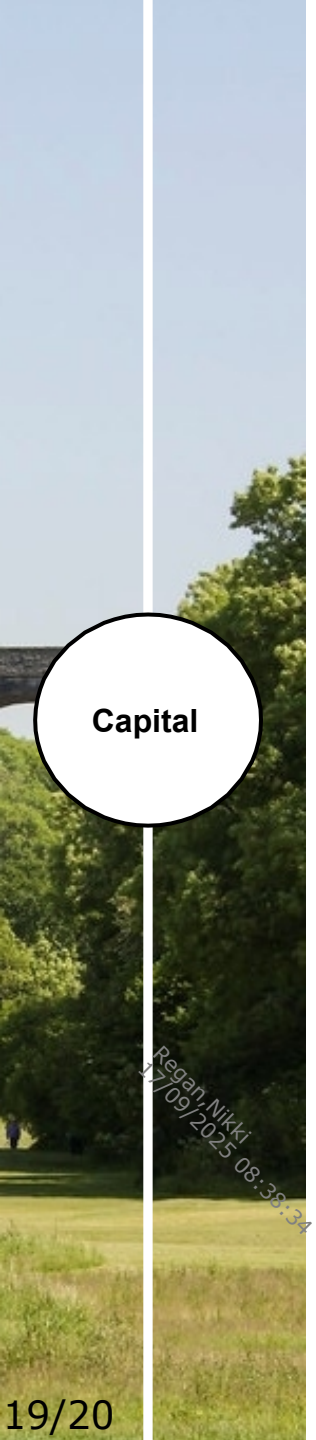
The cumulative cash drawn at the month end against the UHBs cumulative annual cash drawing limit is illustrated by the graph to the right.

Unconfirmed Drawing Limit Allocations as of 31st August 2025	£'000s
Pay award funding 2025-26 (non RLW)	34,968
Pay Award Funding Real Living Wage RLW2025_26 - Additional Employer Costs	3,344
Vertex (JCC)	5,230
Real Living Wage (Care Homes)	4,612
New Medical Training Posts 2017 to 2024	2,019
ATMPs (JCC)	1,944
Urgent & Emergency Care Fund	1,480
GP IM&T Refresh Programme	1,225
Consultant Clinical Excellence Award / Consultant Impact Award	1,002
RTT Waiting Times_Q1 Plans	1,000
Prevention And Early Years AHW - Early Prevention	881
Neurodivergence Improvement Programme	793
AWTCC Voluntary Scheme For Branded Medicines Pricing, Access And Growth (VPAG) Investm	600
Dols / MCA / Advocacy (MH)	572
Planned Care Transformation Fund	565
A2A Sanctuary	503
Individual Placement & Support In Primary Care	440
Genomics (C&V / JCC	323
Women's Health - Pathfinder Establishment (Women's Health Hubs)	300
Welsh Risk Pool	(5,702)
Other	1,688
Total Anticipated Funding £'000s	**57,786**

Summary of Potential Cash Shortfall at Year End	£'000s
Outstanding allocations	57,786
Strategic Support	56,233
Working capital requirement prior year liabilities paid in 2025-26	17,000
Welsh Risk Pool settlements in advance of reimbursement	tbc
Total £'000s	**131,019**

Public Sector Payment Compliance

The UHB's public sector payment compliance performance is above the target of 95%. Performance for the month to the end of August was 96% for the year to date.

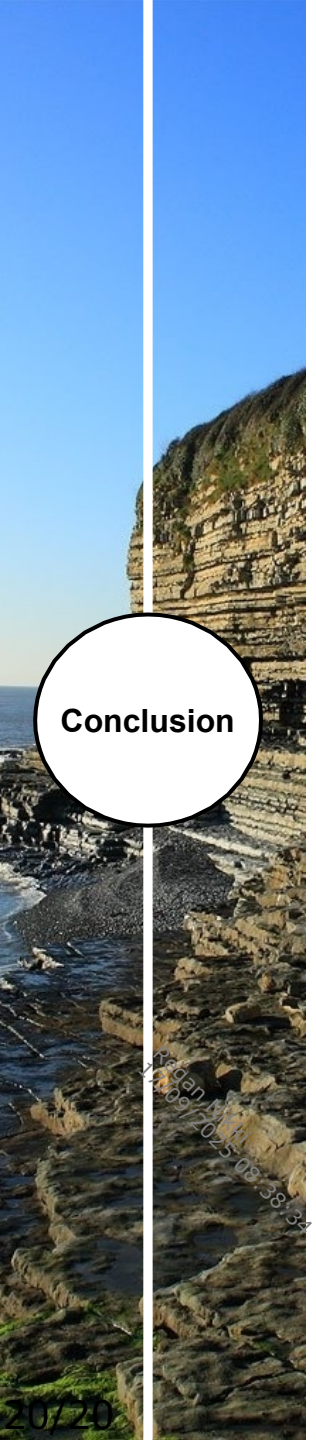


The UHBs approved capital resource limit is £37.052m in line with the latest Capital Resource Limit (CRL) received from Welsh Government on the 11th August 2025. This comprises of £14.317m discretionary funding , £21.614m towards specific projects (including Decarbonisation Funding, Lift Refurbishment and Pentyrch Surgery) and £1.121m relating to IFRS 16 lease capital funding.

The capital programme is planned and monitored through the UHBs Capital Management Group (CMG) and the UHB forecasts that it will remain within its CRL in 2025-26.

2025/26 Capital Programme (£m)	M5 Ytd			Annual	CRL	Plan vs CRL
	Actual	Revised Plan	Variance	Plan	11th August	
All Wales Schemes						
Electrical Infrastructure, Tertiary Tower Block at UHW	0.033	0.030	0.003	1.578	1.270	0.308
Lift Refurbishment and Upgrade, UHW	0.014	0.464	(0.450)	4.201	4.213	(0.012)
Decarbonsation funding - Solar Canopy Car Park	0.459	0.659	(0.200)	2.394	2.394	0.000
Pentyrch Branch Surgery Development 2024-26	0.431	0.375	0.057	4.735	4.735	0.000
Funding for Enabling Project Work – Cardiff & Vale UHB's Estate	0.217	0.229	(0.012)	0.344	0.332	0.012
TEF - Fire	0.070	0.085	(0.015)	0.876	0.876	(0.000)
TEF - Infrastructure	0.007	0.150	(0.143)	3.004	2.959	0.045
TEF - Decarbonisation	0.000	0.000	0.000	0.450	0.450	0.000
TEF - Mental Health	0.000	0.000	0.000	0.352	0.352	0.000
TEF - Infection Prevention Control	0.000	0.000	0.000	0.461	0.461	0.000
TEF - Decontamination	0.106	0.106	0.000	0.811	0.811	0.000
Non-Radiology Ultrasound Replacement	0.000	0.000	0.000	0.468	0.468	0.000
Mental Health Quality and Safety Schemes	0.000	0.000	0.000	0.441	0.441	0.000
Computed Tomography (CT), University Hospital of Wales	0.000	0.000	0.000	0.700	0.700	0.000
DPIF						
DPIF - Medicines and Prescribing: Electronic Prescribing and Medicines	0.000	0.000	0.000	0.520	0.520	0.000
DPIF - RISP	0.000	0.079	(0.079)	0.632	0.632	0.000
IFRS16	0.000	0.000	0.000	1.121	1.121	0.000
Discretionary						
IM&T:	0.490	0.704	(0.214)	2.094	0.500	1.594
Equip	0.148	0.205	(0.057)	1.000	1.000	0.000
Stat comp	0.774	0.670	0.104	2.600	2.800	(0.200)
Other	1.506	2.052	(0.545)	9.291	10.017	(0.726)
Donated				(1.021)	0.000	(1.021)
Total	**4.256**	**5.807**	**(1.551)**	**37.052**	**37.052**	**0.000**

Individual All Wales Schemes variance vs CRL are managed within the discretionary capital allocation and have been agreed as part of the draft programme. All schemes are expected to broadly deliver in year in line with forecast.



Conclusion

The UHB's draft financial plan of a £58.2m deficit was noted by the Board but not approved by Welsh Government due to the failure to meet statutory obligations. Following the submission of the plan, Welsh Government asked the UHB to detail further actions to reduce the forecast deficit of £58.2m. In response, the UHB confirmed that progress in the identification of savings provided the UHB with sufficient assurance to increase planned savings delivery by £2m which in turn has reduced the forecast 2025/26 deficit position to £56.2 million.

The reported month 5 position is £2.913m above plan primarily due to a £1.466m deficit against the month 5 Quality Improvement Programme Savings target.

At Month 5 the Committee are requested to:

- **NOTE** the reported year to date position is an overspend of £27.809m and the forecast deficit of £56.2m.

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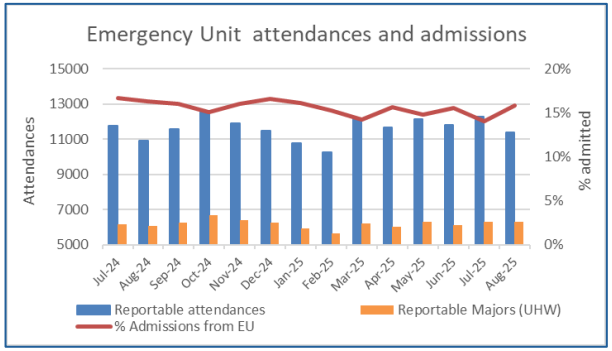
- **NOTE** the month 4 operational overspend against plan of £2.913m and the £1.466m savings deficit
- **NOTE** the progress against the savings target, with £28.894m (90.2%) of green and amber schemes identified at Month 5 against the revised £32m target.
- **NOTE** that delivery of the forecast is also predicated on the confirmation of all expected income streams.
- **NOTE** the £8.480m recurrent savings shortfall impacting adversely on a deteriorating underlying deficit being carried into 2026/27
- **NOTE** the is a potential £131.0m cash shortfall at year end before outstanding cash allocations and strategic support are confirmed by Welsh Government.

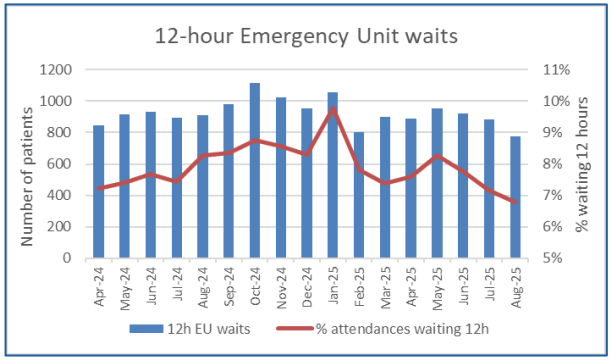
CARDIFF & VALE UHB
OPERATIONAL PERFORMANCE REPORT
– September 2025

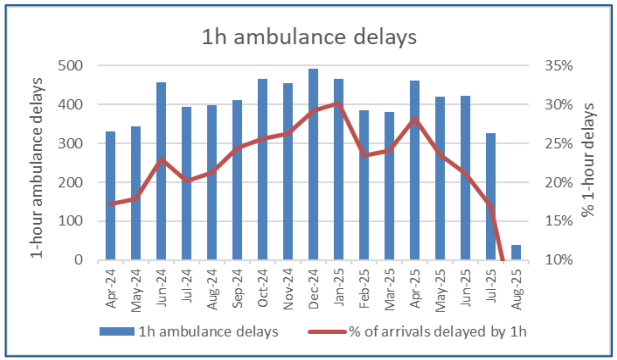

Urgent and Emergency Care
Out of hospital and EU
Flow and discharge
Planned Care
Primary and Community
Mental Health
Productivity and efficiency

Urgent and Emergency Care – Out of Hospital and Front Door

- In August attendances at the Emergency Unit decreased from those in July but were increased compared to August '24. The number of Majors remained similar to July '25. The proportion of patients admitted via EU increased to 15.8% but is reduced when compared to August '24
- The summer has seen periods of significant operational pressure, impacting flow through the hospital and waits in the EU. Our organisational response including a "reset week" and business continuity-like actions in Medicine Clinical Board has led to some recent improvements
- The number of patients wating 12 hours or more in EU reduced in again in August and represented 6.8% of attendances. The number of patients waiting 24 hours in the EU footprint reduced to 2
- The number of 1-hour ambulance holds was significantly reduced in August – 2% of conveyances waited >1h at UHW. In line with the Ministerial Group recommendations, we have moved our operational focus to reducing and eliminating 45-minute ambulance holds. In August, the number of 45-minute holds at UHW reduced to 114 from 578 in July.

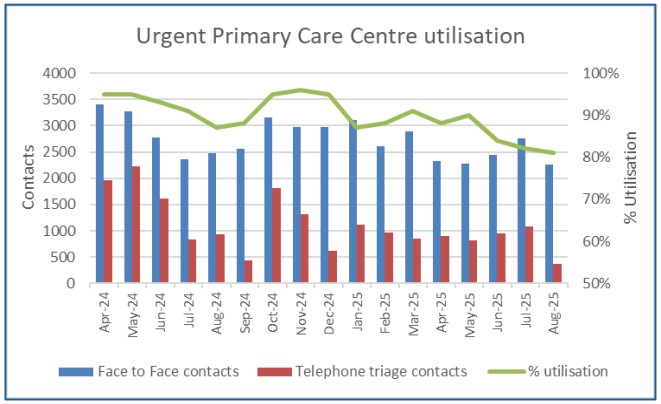




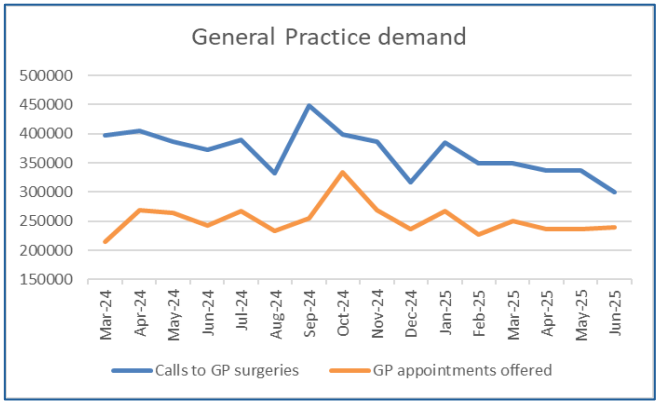


Urgent and Emergency Care – Out of Hospital and Front Door

- In August, over 2,250 patients attended Urgent Primary Care Centres across Cardiff and the Vale, with a further 369 patients triaged by telephone. In August 81% of the available slots were utilised
- In 24/25 there were over 4.5 million calls to GP surgeries, with over 3.1 million appointments offered
- Calls to surgeries has seen a downward trend over the past 3-years, while digital requests have increased
- The number of appointments offered in June increased slightly from the previous month
- We continue to see pressure across GMS with our primary care team supporting practices where required

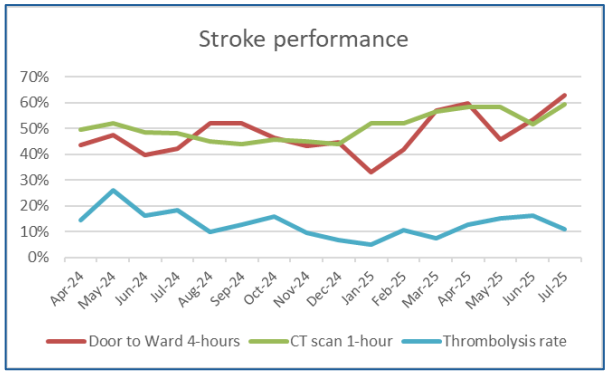


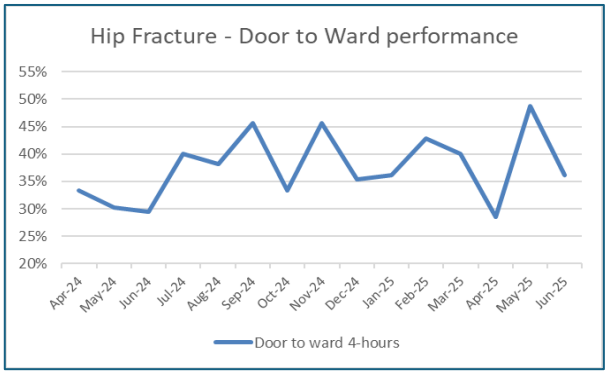
GMS activity	June 2025	Year to date 24/25
Calls to GP surgeries	299,062	973,280
Digital requests to GP practices	77,504	227,131
GP appointments offered	238,836	710,500
Items issued via presciption	749,932	2,145,753

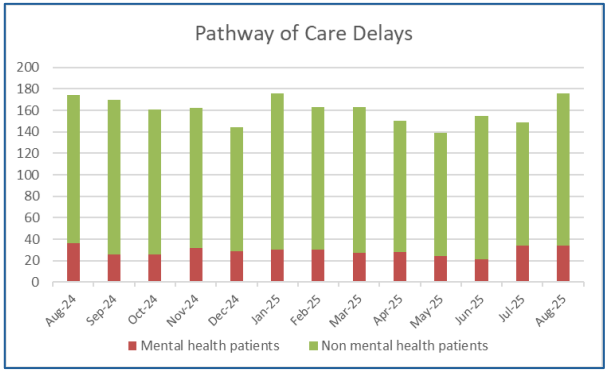


Urgent and Emergency Care – Hospital Flow and Discharge

- The most recent data from July showed an improvement in compliance with the Door to Ward standard for Stroke patients. Compliance rose from 53.6% to 62.9%. In July 59.5% of patients receiving their CT scan within 1-hour, increased from June
- In June, 36% of Hip Fracture patients were admitted to the ward within 4-hours. This represents a reduction in performance from May in line with the increased operational pressures in month, but remains significantly above the national average of 9%
- Pathway of Care Delays increased in August 2025 to 176, the number of non-mental health delays increased, mental health delays remained the same. We continue to focus on reducing delays and the length of inpatient stays, working with our partners in the local authorities to reduce delays throughout the assessment and discharge process







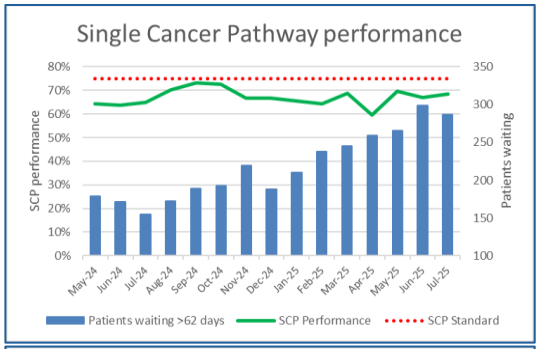
Planned Care, Cancer and Diagnostics

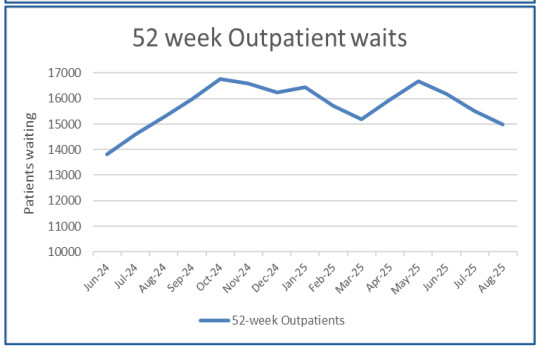
- The number of patients waiting >62 days for Cancer treatment has risen since last summer. In July compliance with the Single Cancer Pathway standard increased to 68.4%

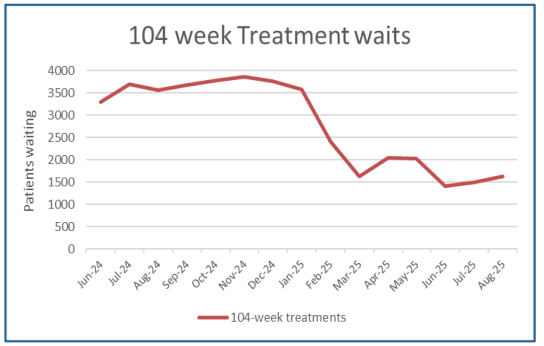
- The number of patients waiting 52-weeks for an outpatient appointment reduced in August 2025 driven by surgical specialties. We are working closely with Welsh Government on national schemes to undertake c33,000 additional outpatient appointments through this year. The first clinics took place in August and a monthly update will form part of future updates to F&P Committee

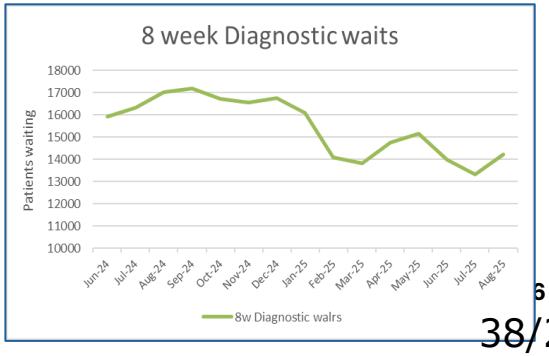
- The number of patients waiting 2-years for treatment increased in August to 1,622, in line with our trajectory. Following delivery of our commitment in Q1, we have committed to delivering a further reduction by the end of Q2. This is tracked daily, with weekly updates to the COO, CEO and Chair

- Diagnostic 8-week waits increased in August 2025 to 14,243, mainly driven by increased in Radiology waits. NOUS waits increase but remain lower than Q1. The MRI position increased by 450 patients. The 8-week position in Endoscopy remained stable



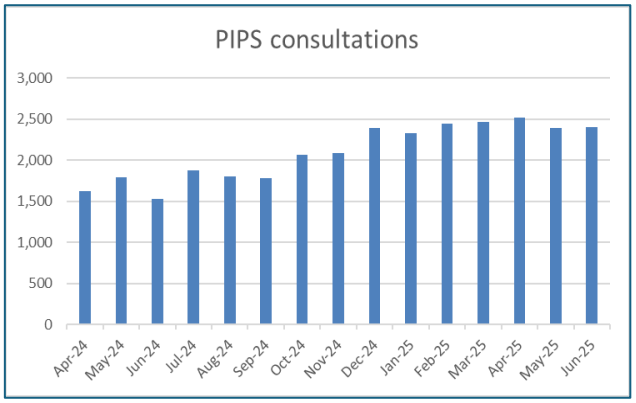


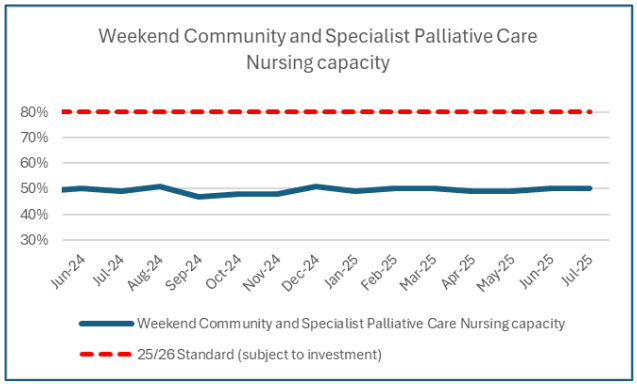


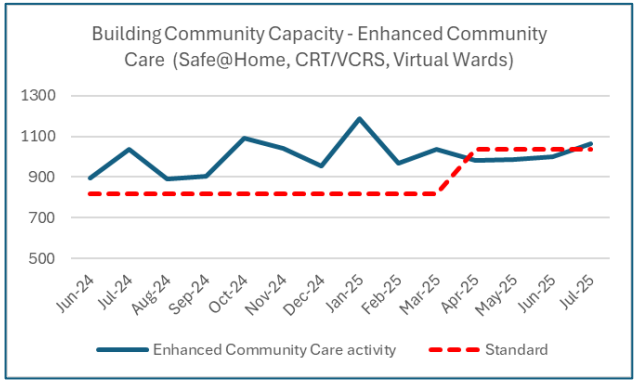


Primary and Community Care

- We continue to see demand pressures across Primary Care, with PCIC supporting practices at high escalation levels. Health Board monitoring reports 100% compliance with access standards through 24/25 and into Q1 25/26
- The General Dental Service delivered 98.5% of the contract value in 24/25. So far 23.4% has been delivered in 25/26, ahead of our delivery at this point last year
- Community Pharmacy continues to develop the Pharmacist Independent Prescribing Service, with 2,398 consultations delivered in June 2025, increased from May
- Our community teams continue to deliver a significant volume of activity to patients outside a secondary care setting. District Nursing contacts exceeds the number of visits to EU on a monthly basis and we have increased weekend capacity from 23/24 levels and look to increase further
- In 24/25 the Health Board exceeded the baseline for delivery of Enhanced community care capacity. We continue to develop these services, including a single point of access for enhanced community services, in July we met our ambition of a 20% increase this year

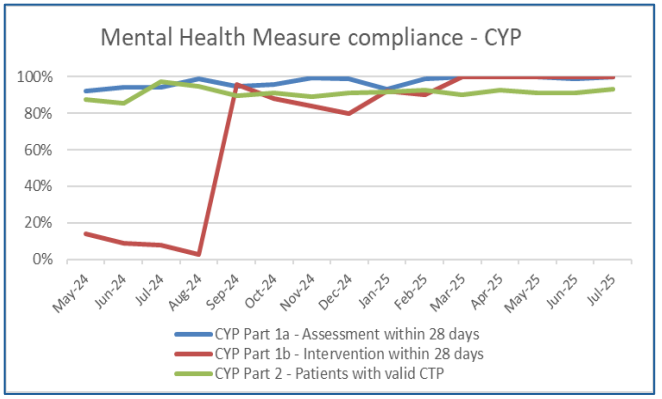


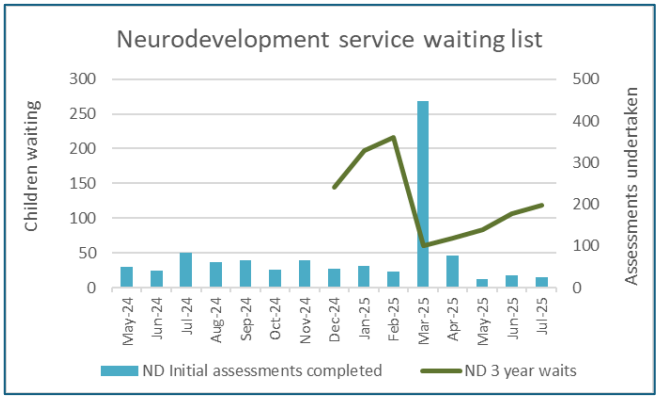


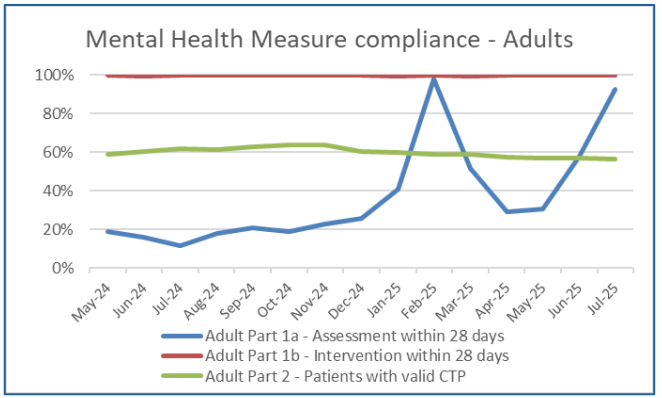


Mental Health

- For Children and Young People, Part 1a and 1b remain compliant despite high demand, 100% compliance reported for July 2025. Part 2 performance also remains compliant, with over 90% compliance maintained throughout 2025
- The Neurodevelopment service waiting list continues to grow with >560 referrals in June. The service anticipate the number of children waiting 3 years for assessment will grow throughout 2025 with the current capacity. The number of 3-year waits increased to 118 in July. In total there are 4,512 children on the waiting list for assessment
- For Adult and older people's mental health services, July saw an increase in Part 1a compliance to 92%, despite referrals remaining high. Part 1b remains compliant with 99.8% reported in July. Part 2 compliance remained low despite ongoing actions, a revised trajectory is being developed for September to reflect the need to address both performance and data submission challenges.



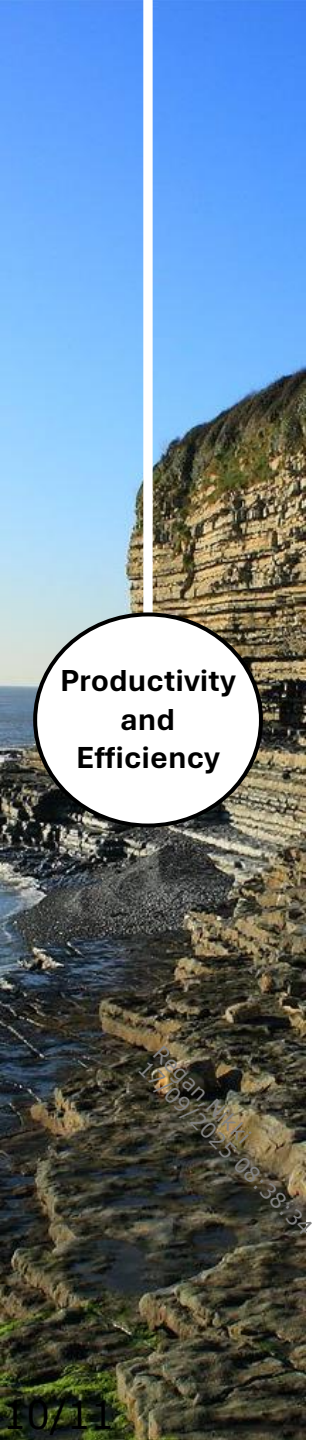




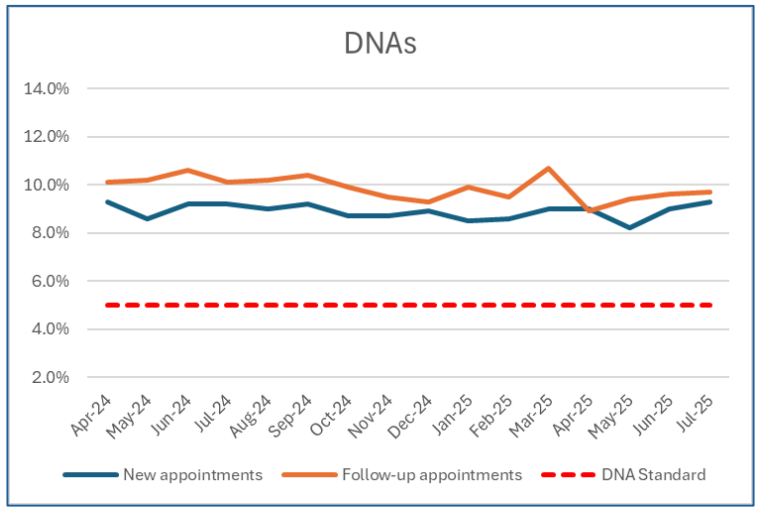
Mental Health Measures:
1a – assessments undertaken within 28 days
1b – therapeutic interventions undertaken within 28 days following assessment
2 – residents with a valid health and care treatment plan

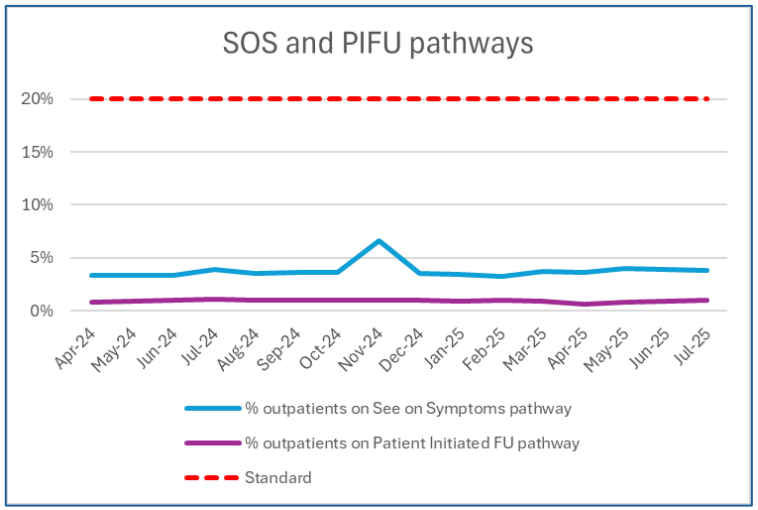
Productivity and Efficiency

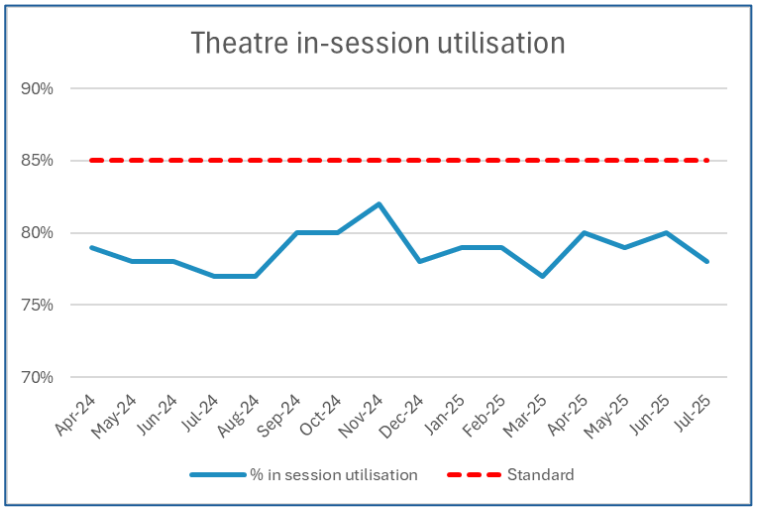
Measure		Standard	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Trend
Outpatients	% DNAs - New appointments	5%	9.2%	9.0%	9.2%	8.7%	8.7%	8.9%	8.5%	8.6%	9.0%	9.0%	8.2%	9.0%	9.3%	
	% DNAs - Follow-up appointments	5%	10.1%	10.2%	10.4%	9.9%	9.5%	9.3%	9.9%	9.5%	10.7%	8.9%	9.4%	9.6%	9.7%	
	% outpatients on See on Symptoms pathway	20%	3.9%	3.5%	3.6%	3.6%	6.6%	3.5%	3.4%	3.2%	3.7%	3.6%	4.0%	3.8%	3.8%	
	% outpatients on Patient Initiated FU pathway		1.1%	1.0%	1.0%	1.0%	1.0%	1.0%	0.9%	1.0%	0.9%	0.6%	0.8%	0.8%	1.0%	
Endoscopy	% room utilisation	90%	81%	74%	74%	68%	78%	75%	83%	82%	88%	78%	88%	81%	87%	
	% utilisation (activity points available)	95%	81%	80%	83%	85%	87%	85%	84%	81%	84%	87%	89%	87%	90%	
Theatres	Average turnaround time (minutes)	10	17.0	16.0	18.9	19.9	15.9	16.2	15.9	18.2	17.1	16.6	15.9	17.5	17.0	
	% of theatre session utilisation	95%	80%	75%	79%	83%	84%	75%	88%	85%	87%	79%	83%	80%	81%	
	% in session utilisation	85%	77%	77%	80%	80%	82%	78%	79%	79%	77%	80%	79%	80%	78%	
	<24 hour elective cancellations	N/A	309	249	190	363	198	217	315	295	347	237	229	281	287	
Waiting list	Total RTT waiting list volume	N/A	153,560	153,673	155,063	156,194	154,994	154,605	153,519	151,069	151,226	152,150	152,901	151,955	150,902	
Inpatient	Delayed pathways of Care - Mental Health	217	29	36	26	26	32	29	30	30	27	28	24	21	34	
	Delayed Pathways of Care - non-Mental Health		142	138	144	135	130	115	146	133	136	122	115	134	115	
	7 day LOS on Acute Wards (snapshot)	<40%	55.5%	58.0%	58.5%	59.4%	57.3%	62.3%	60.5%	59.4%	56.2%	57.8%	61.0%	59.3%	56.9%	
	21 day LOS on Acute Wards (snapshot)	<20%	30.9%	32.6%	31.8%	31.4%	30.9%	35.5%	37.3%	34.0%	34.0%	33.4%	33.4%	32.3%	32.0%	
	Medicine (all services) non-elective LOS (on discharge)	N/A	10.9	11.3	11.9	10.7	10.4	10.5	9.8	12.4	11.0	10.3	11.9	9.8	10.9	
Urgent and Emergency	Reportable attendances	N/A	11,773	10,926	11,567	12,628	11,922	11,468	10,756	10,237	12,193	11,659	11,517	11,823	12,304	
	Reportable Majors attendances	N/A	6,182	6,053	6,235	6,691	6,398	6,272	5,924	5,628	6,210	6,041	6,297	6,113	6,295	
	Reportable EU admissions	N/A	1,865	1,778	1,768	1,823	1,831	1,829	1,676	1,502	1,658	1,754	1,708	1,762	1,733	
	SDEC attendances	N/A	1,699	1,736	1,730	1,847	1,716	1,601	1,786	1,609	1,770	1,678	1,779	1,753	1,908	
Mental Health	TBC	TBC - will be added from Q3														

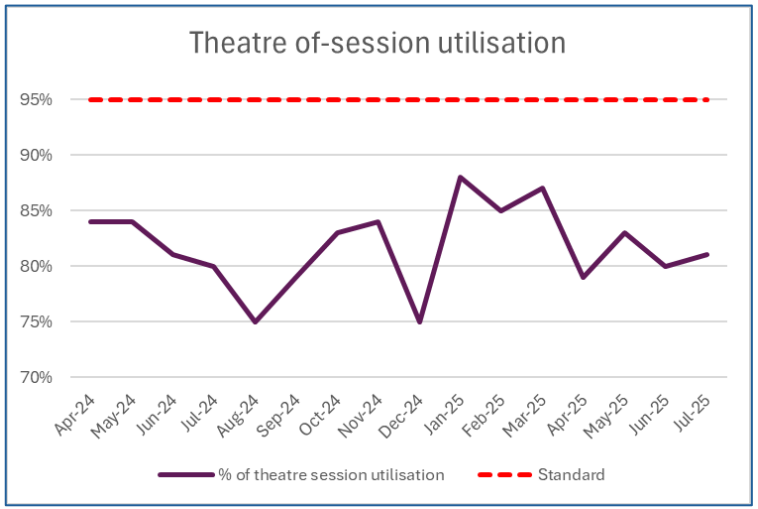


Productivity and Efficiency









Recommendation:			
The Board/Committee (*delete as appropriate*) are requested to: a) **NOTE** the year to date position against key organisational performance indicators for 2025-26 and the update against the Operational Plan programmes.			
Link to Strategic Objectives of Shaping our Future Wellbeing: *https://shapingourfuturewellbeing.com/*			
Putting People First 1. **Click the objective above to view more detail.**	Providing Outstanding Quality 2. **Click the objective above to view more detail.**	Delivering in the Right Places 3. **Click the objective above to view more detail.**	Acting for the Future 4. **Click the objective above to view more detail.**
	x	x	

Five Ways of Working (Sustainable Development Principles) considered				
Prevention	Long term	Integration	Collaboration	Involvement
	x	x		

Quality Impact Assessment Completed?				
Yes – (***please provide completed QIA document***)		No – (***Please provide reasoning, e.g. not required***)	x	Not required

Impact Assessment:	
Risk: No	Reputational: No
Safety: No	Socio Economic: No
Financial: No	Equality and Health: No
Workforce: No	Decarbonisation: No
Legal: No	Welsh Language: No

Approval/Scrutiny Route *(please note anywhere else this paper has been before)*:	
Committee/Group/Exec	Date:

Cardiff and Vale
Integrated Performance Report

2025/26

September 2025

Report Contents

Click on a hyperlink to navigate directly to the section required

Section 1: Cabinet Secretary Priorities

Return to Main Menu

The Cabinet Secretary for Health and Social Services has set out National Programmes of work covering the priority areas of delivery. These priority areas are:

- Timely access to care
- Population health and prevention
- Building community Capacity
- Mental health access
- Women's health

Further to these priority areas the Welsh Government and NHS Wales have identified Key Delivery Expectations across Urgent and Emergency Care, Cancer, Diagnostics, Elective Care and Mental Health Services.

Section 1 provides an overview of the Health Board performance of the Key Performance Indicators outlined by Welsh Government and Health Board commitments related to the delivery of the priority areas.

For a more in-depth view on performance for each priority, please follow the links in the NHS Performance Report column.

Performance ambition for 25/26 are in line with our annual plan, which has not been agreed with Welsh Government

Section 1: Cabinet Secretary Priorities

Return to Main Menu

Priority	Aim	C&V Commitment	Commitment to meet national standard?	By When	In Month Performance against C&V commitment	Link in Performance Report
Building community Capacity	**Measure:** Number of delayed transfers of care. **National standard/ambition:** 12 month reduction trend **Reporting period:** Monthly	**<160**	**Yes**	**Q4**	**176** Jul-25	Hyperlink to section
	Measure: General Medical Services – Number of GP practices achieving core access standards **National standard/ambition:** 100% **Reporting period:** Annual – in month position for information	**100%**	**Yes**	**Q4**	**98.2%** Apr-24	Hyperlink to section
	Measure: Increase in number of people accessing Pharmacist Independent Prescribing Service for acute minor conditions and routine contraception **National standard/ambition:** Increase **Reporting period:** Monthly	**>2,185**	**Yes**	**Q2**	**2,398** Jun-25	Hyperlink to section
	Measure: Increase in capacity at the weekend of community nursing and specialist palliate care **National standard/ambition:** 80% **Reporting period:** Monthly	**>51%** Increase from 24/25	**No**	**Q4**	**50%** **Jun-25**	Hyperlink to section
	Measure: Increase capacity of Enhanced Community Care **National standard/ambition:** Meet and exceed 24/25 requirement where possible (24/25 baseline) **Reporting period:** Monthly	**1,038** 20% increase from 24/25	**Yes**	**Q1**	**1,001** **Jun-25**	Hyperlink to section

Performance Key: Meeting standard / trajectory | off target/trajectory

Section 1: Cabinet Secretary Priorities

Return to Main Menu

Priority	Aim	C&V Commitment	Commitment to meet national standard?	By When	In Month Performance against C&V commitment	Link in Performance Report
Population health and prevention	**Measure:** Increase in % of patients (aged 12 and over) with diabetes who received all eight NICE recommended care processes **National standard/ambition:** Increase **Reporting period:** Monthly	48%	Yes	Q4	46.1% Jun-25	Hyperlink to section
Mental health access	**Measure:** Percentage of mental health assessments undertaken within (up to and including) 28 days from the date of referral for people age under 18 years **National standard/ambition:** 80% **Reporting period:** Monthly	80%	Yes	Q1	100% Jul-25	Hyperlink to section
	Measure: Percentage of mental health assessments undertaken within (up to and including) 28 days from the date of referral for adults age 18 years and over **National standard/ambition:** 80% **Reporting period:** Monthly	80%	Yes	Q1	99.8% Jul-25	Hyperlink to section
	Measure: Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people age under 18 years **National standard/ambition:** 80% **Reporting period:** Monthly	80%	Yes	Q1	100% Jul-25	Hyperlink to section
	Measure: Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for adults age 18 years and over **National standard/ambition:** 80% **Reporting period:** Monthly	80%	Yes	Q1	92.4% Jul-25	Hyperlink to section

Performance Key: Meeting standard / trajectory | off target/trajectory

Section 1: Cabinet Secretary Priorities

Return to Main Menu

Priority	Aim	C&V Commitment	Commitment to meet national standard?	By When	In Month Performance against C&V commitment	Link in Performance Report
Timely access to care	**Measure:** Reduce the number of ambulance patient handovers over 1 hour **National standard/ambition:** Zero **Reporting period:** Monthly	**<400**	**No**	**Q4**	**39** Aug-25	Hyperlink to section
	Measure: Reduce the number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge **National standard/ambition:** Reduce compared to 24/25 towards zero **Reporting period:** Monthly	**<750**	**Yes**	**Q4**	**774** Aug-25	Hyperlink to section
	Measure: Number of patients waiting more than 104 weeks for treatment **National standard/ambition:** Zero **Reporting period:** Monthly * Our commitment is subject to review as we work with Welsh Government through the year to deliver an improved position	**Original Submission 9,861** **Revised submission 5,491**	**No**	**Q4**	**1,622** Aug-25	Hyperlink to section
	Measure: Improve the percentage of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of referral route) **National standard/ambition:** 12m improvement trend towards 80% by March 2026 **Reporting period:** Monthly	**75%**	**No**	**Q4**	**68.4%** Jul-25	Hyperlink to section
	Measure: Number of patients waiting more than 8 weeks for a specified diagnostic **National standard/ambition:** Zero **Reporting period:** Monthly	**Original submission 10,436 (endoscopy only) - TBC**	**No**	**Q4**	**14,243** Aug-25	Hyperlink to section

Performance Key: Meeting standard / trajectory | off target/trajectory

Section 2: Cardiff and Vale Performance Report

The Performance Report section provides detail of UHB performance across the quadruple aims.

Detail on what is included under each quadruple aim is provided below.

A summary of performance is provided against the priority UHB ambition under each aim, including detail of annual plan commitments. Performance against the relevant NHS Performance Frameworks measures is provided under each aim.

National Performance Framework monitoring data is available from DHCW showing performance across all Welsh Health Boards and Trusts (where relevant). This information can be accessed by clicking here.

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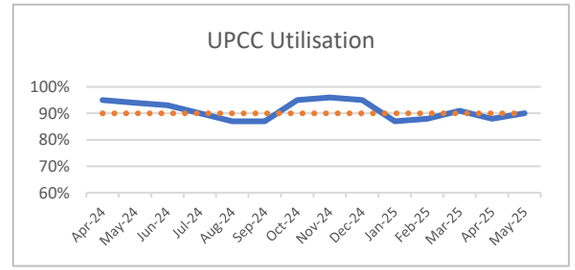
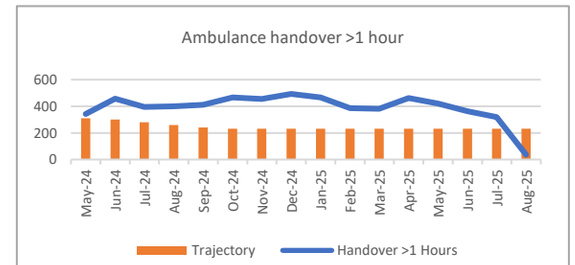
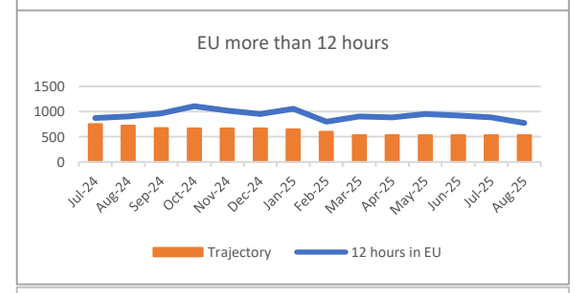
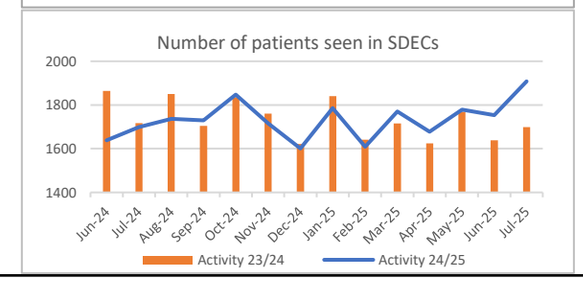
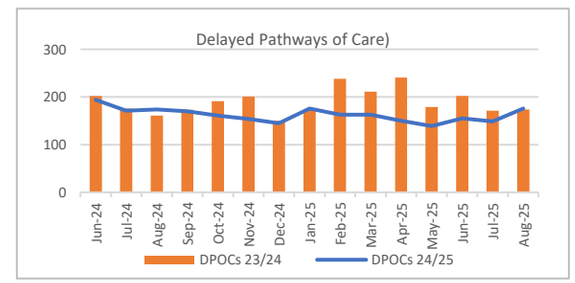
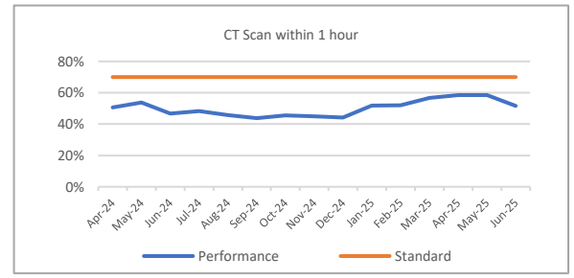
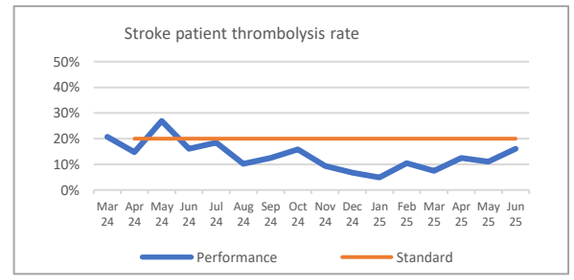
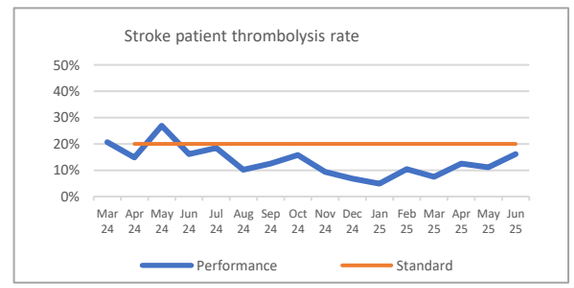
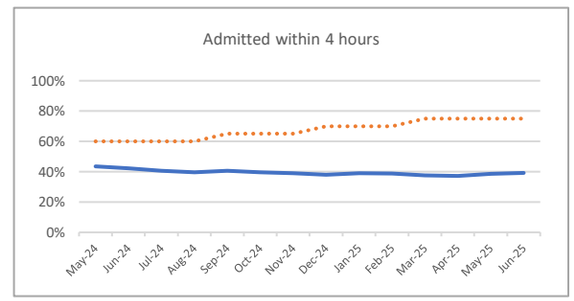
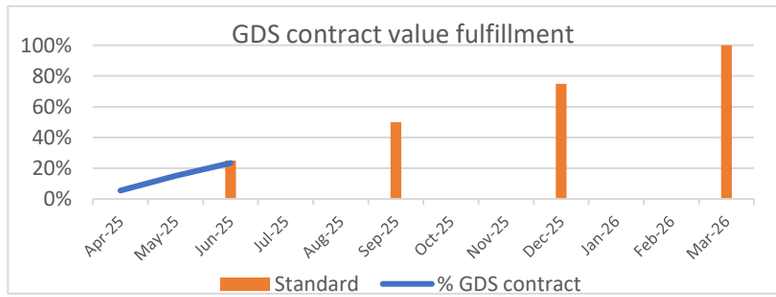
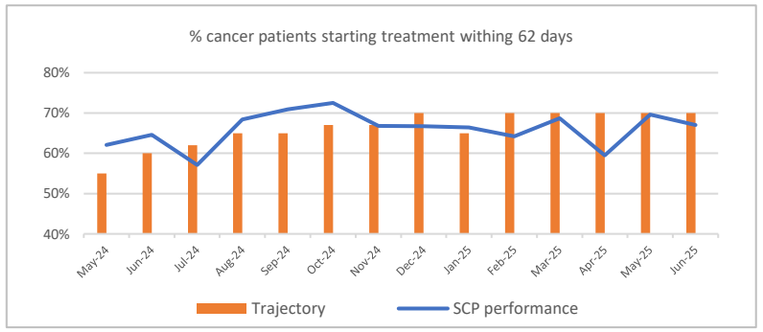
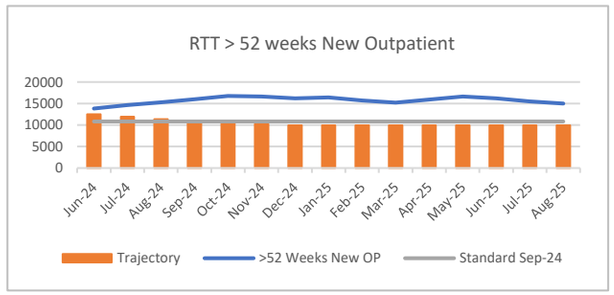
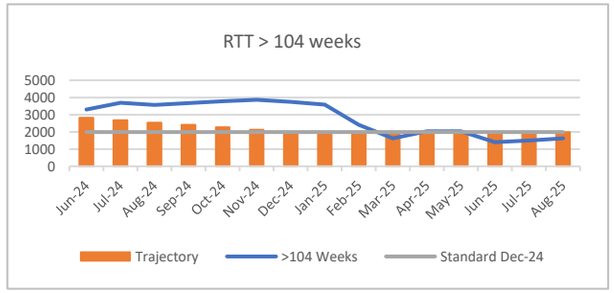
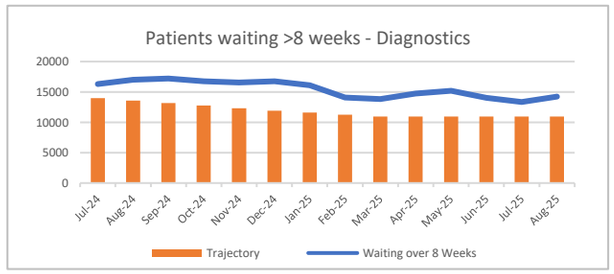
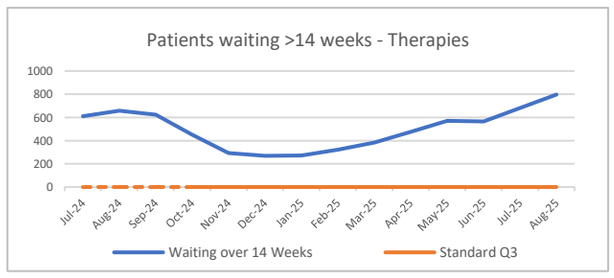
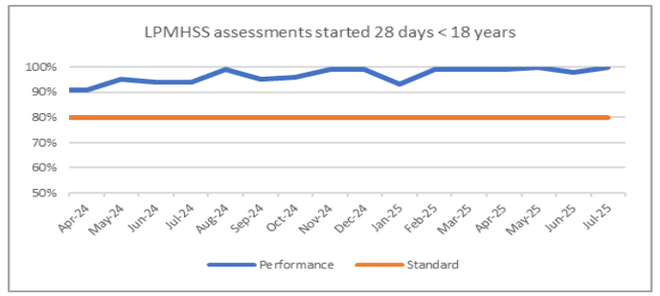
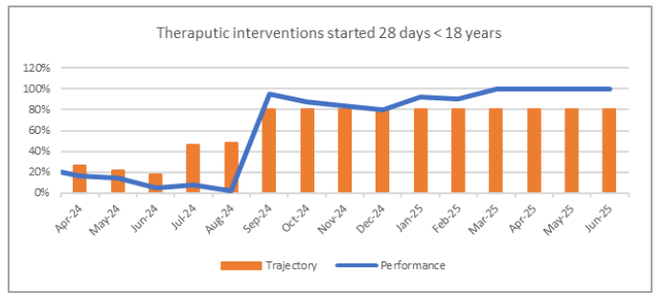
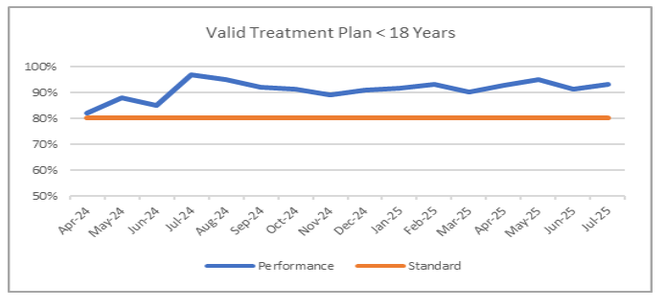
Number	Aim	Contents
Aim 1	People in Wales have improved health and well-being with better prevention and self-management	Public Health
Aim 2	People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement	Urgent and Emergency Care Inpatient Flow, Discharge and Front Door Alternatives to Admission Community and Urgent Primary Care Priority Services RTT Waiting Times Planned Care Cancer, Diagnostics and Therapies Primary and Community Care Whole System Evaluation and Supporting Patients Whilst Waiting Mental Health
Aim 3	The health and social care workforce in Wales is motivated and sustainable	People and Culture
Aim 4	Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes.	Quality, Safety and Experience Financial Performance

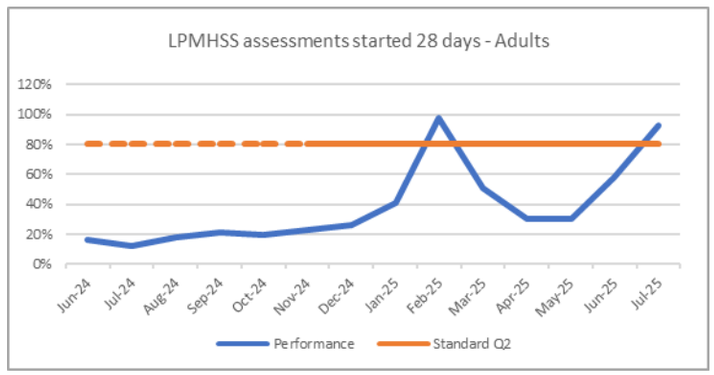
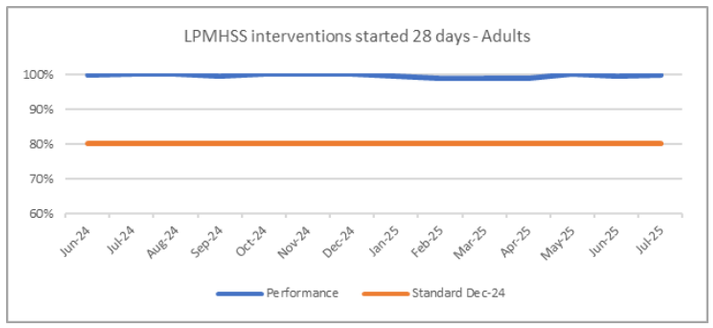
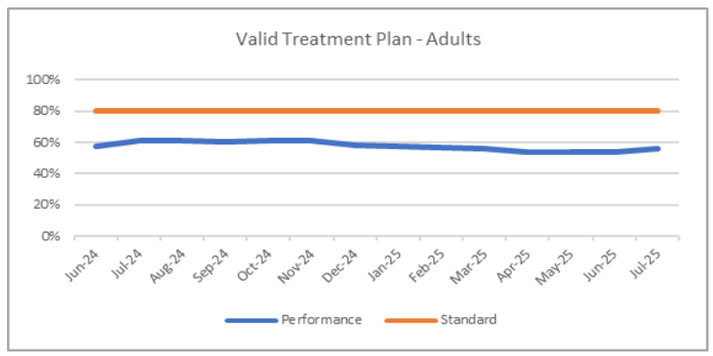
Priority	Performance Summary	Reporting Period	Performance against standard	Data
Primary, Community and Out of Hospital Care	**Urgent Primary Care Centre Utilisation – Maintain 90% utilisation** In August utilisation was 81%, this is below our commitment. We have made changes to the model, combining face to face consultations and use of the triage service within the reporting	Aug-25	81% utilisation Below standard	
	Community visits – 95% of face-to-face visits within 8 hours Q1 to date 97% compliance with 8-hour standard	Jul-25	97% Above standard	
Emergency Department and Same Day Emergency Care	**Ambulance handover delays – eliminate 2-hour delays. Reduce 1-hour delays to <365 per month from Q1, < 400 per month in Q4** In August we reported zero 2-hour ambulance delays, a reduction from June, and delivering our commitment to eliminate 2-hour delays. In August we reported 39 1-hour ambulance delays, a significant reduction from July and below our commitment of <365 In August lost minutes per arrival reduced further to 11, a significant improvement reflecting the reduced delays noted above	Aug-25	0 2-hour delays At standard 39 1-hour delays Below standard 11 minutes lost/arrival Above standard	
	ED waits - No patients waiting >24 hours in ED, <700 patients waiting <12 hours in ED per month in Q1 and Q4, <650 in Q2 and Q3 In August we reported a decrease in patients waiting 12-hours in EU compared to July. This equates to 93.2% of attendances waiting less than 12-hours and below our ambition for Q4	Aug-25	93.2% patients <12h Below standard	
	SDEC units In July we reported an increase in activity compared to June, and above July 2024 activity. A drop in medical SDEC has been noted and the team have identified a potential underreporting of attendances which is being investigated – attendances are forecast to increase	Jul-25	1908 SDEC attends Below standard	
Reducing time in hospital and Continuity of Care	**Length of stay - <20% patients in acute beds to have a LOS >21 days, <40% patients in acute beds to have a LOS >7 days** This data is a monthly snapshot taken at on the final Friday of each month. At the end of August 56.9% of patients in acute beds had a LOS of >7 days, 34.9% >21 days – increased from July	Aug-25	58.4% >7d Above standard 34.9% >21d Above standard	
	Pathway of Care Delays – <160 delayed patients each month In August 2025 the number of POCDs was 176 – this is above the number of delays reported in July 2025. We continue to work internally and with LA partners to reduce the number of POCD	Aug-25	176 Above standard	

Priority	Performance Summary	Reporting Period	Performance against standard	Data
High Impact Pathways - Stroke	**CT scan – 70% of patients scanned within 1 hour of arrival at EU** In July 59.5% of patients were received their CT scan within 1 hour of arrival at EU, increased from June. **Thrombolysis – 20% thrombolysis rate** In July 10.8% of stroke patients were thrombolysed, We are clinically reviewing internally and working with colleagues from NHS Executive **Admission – 80 % of patients admitted directly to the stroke unit within 4 hours** In July 62.9% of patients were admitted directly to the Stroke Unit within 4 hours. Door-to-ward pathways continue to be impacted by operational pressures within the Emergency Unit Our door-to-ward and CT Stoke performance measures are below our ambitions for performance on the stroke pathway. We have seen considerable improvements compared to last year – a business case for development of the service has been approved and will allow more sustainable improvements to be embedded Overall Stroke performance is assessed through the Sentinel Stroke National Audit Programme (SSNAP) – which uses metrics across the whole patient pathway. In the most recent assessment period UHW received a grade B. The SSNAP criteria have changed for this year and will be reflected in the 25/26 IPR following conclusion of National discussions around KPIs for Wales	Jul-25	59.5% CT Below standard 10.8% Thrombolysis Below standard 62.5% Door-to-ward Below standard	  
High Impact pathways – Hip fracture	**Hip Fracture** Door to Ward time is the first KPI used by the National Hip Fracture Database to monitor national performance across the patient pathway. In June our annualised compliance showed 39.1% of patients were admitted to the ward within 4 hours. This is below our ambition but well above the national average of 9.2%.	Jun-25	39.1% (Annualised) Below standard	

Priority	Performance Summary	Reporting Period	Performance against standard	Data
Primary and Community Care	**GMS access – 100% of practices achieving core access standards** In April 100% of practices met the standard – the official data is provided annually but our monthly tracking data will be updated here for information **GDS access – 25% of contract value by end Q1, 50% Q2, 75% Q3, 100% Q4** At the end of March 98.5% of the contract value had been delivered. So far in 25/26 (data to June) 23.5% of the contract value has been delivered **Pharmacy access – >2185 accessing Pharmacy Independent Prescriber service** In June 100% of practices were providing CCPS services, providing 2398 consultations **Optometry – 95% of practices providing WGOS1+2** All practices are currently providing WGOS 1&2	Apr-25 Jun-25	100% At standard 23.5% Below standard (Apr-25 – Jun 25) 2,398 Above standard 100% Above standard	
Cancer	**Single Cancer Pathway – 75% of patients to receive their first definitive treatment within 62 days by Q4** In July 68.4% of patients received their first definitive treatment within 62 days. This is below our ambition. In recent months we have seen the number of patients waiting >62 days for treatment increase and performance is challenged as a result of treating the longest waiting patients in month.	Jul-25	68.4% Below standard	

Priority	Performance Summary	Reporting Period	Performance against standard	Data
Outpatient and Treatment waiting times	**Outpatient waiting times – Reduction in the number of patients waiting 52 weeks for a first outpatient appointment** In August there were 14,990 patients waiting 52 weeks for their first outpatient appointment. This is improved from July, additional actions are outlined in the cover paper **Treatment waiting times – Reduction in the number of patients waiting 104 weeks for treatment** In August there were 1,622 patients waiting 104 weeks for treatment. This is an increase from July but in line with the trajectory shared with Welsh Government. We are working to deliver a reduction by the end of Q2 and will work with Welsh Government to continue to improve the position through the year	Aug-25	14,990 patients Above standard 1,622 patients Above standard (Q2)	 
Diagnostics and Therapies	**Diagnostics – Reduction in the number of patients waiting over 8 weeks for a specified diagnostic** In August 14,243 patients were waiting over 8 weeks for a specified diagnostic, A increase from July, Improvement in the radiology position this month, with NOUS waits notably reduced. **Therapies – National standard of zero 14 week waits** In August 797 patients were waiting over 14 weeks for therapies, An increase from July. Breaches are concentrated in OT, Dietetics and Physiotherapy and team are working to bring the specific services back into balance. Physiotherapy has seen a significant reduction in waits since Q3 24/25	Aug-25	14,243 patients Diagnostics Above standard 797 patients Therapies Above standard	 

Priority	Performance Summary	Reporting Period	Performance against standard	Data
Paediatric waiting times	**New Outpatient waits – 0 patients waiting over 52 weeks for outpatients in Q1** In August there were 0 patients waiting over 52 weeks for a new outpatient appointment	Aug-25	0 Meeting standard	
Emotional Health and Wellbeing	**Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for under 18s – 80% compliance with the Standard of <28 days** In July 100% of assessments were completed within 28 days		98% Part 1a Above standard	
	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for under 18s – 80% compliance with standard In July 100% of interventions were started within 28 days, this is above the standard for Q3 and in line with the forecasts for the early part of this year	Jul-25	100% Part 1b Above standard	
	Percentage of patients with a valid Care and Treatment plan – 80% compliance with standard In July 93% of patients had a valid Care and Treatment Plan, above our ambition		93% Part 2 Above standard	

Priority	Performance Summary	Reporting Period	Performance against standard	Data
Mental Health Measures – Part 1a	**Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for adults aged 18 years and over – 80% compliance with the Standard of <28 days** In July 92% of patients received their assessment within 28 days. Referrals to the service remain high.	Jul-25	92.4% Part 1a Above standard	
Mental Health Measures – Part 1b	**Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for adults – 80% compliance with standard** In July 99.8% of therapeutic interventions were started within 28 days of assessment, above the standard and in line with our trajectory submitted to Welsh Government.	Jul-25	99.8% Part 1b Above standard	
Mental Health Measures – Part 2	**Percentage of patients with a valid Care and Treatment plan – 80% compliance with standard** In July 56.2% of patients had a valid Care and Treatment plan, a small decrease from April following focused work from the teams. Performance remains below the standard– the RAMP protocol and Part 1 schemes have been approved though the Mental Health Liaison Committee to support longer term improvements in compliance	Jul-25	56.2% Part 2 Below standard	

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
11.	Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours	2023/24	100%	**100%** At standard	19/20: 93.4%; 20/21: 95.0%; 21/22: 96.5%; 22/23: 98.2%
12.	Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	Jun-25	Improvement compared to the same month in the previous year	**46.1%** Above standard	Mar-25: 46.30%; Apr-25: 46.50%; May-25: 45.90%; Jun-25: 46.10%
13.	Percentage of the primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)	Apr-25 to Jun-25	A month on month increase towards a minimum of 30% contract value delivered by 30 September 2024 and 100% by 31 March 2025	**23.4%** Above standard	Apr-25: 5.50%; Apr25 - May-25: 15.10%; Apr-25 - Jun-25: 23.40%
14.	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Jun-25	Increase compared to the same month in the previous year	**2,398** Above standard	Mar-25: 2465; Apr-25: 2516; May-25: 2388; Jun-25: 2398
15.	Percentage of Local Primary Mental Health Support Service (LMPHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for people aged under 18 years	Jun-25	80%	**98%** Above standard	Mar-25: 99%; Apr-25: 99%; May-25: 100%; Jun-25: 98%
16.	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for people aged under 18 years	Jun-25	80%	**100%** Above standard	Mar-25: 100%; Apr-25: 100%; May-25: 100%; Jun-25: 100%
17.	Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for adults aged 18 years and over	Jun-25	80%	**57.9%** Below standard	Mar-25: 51.3%; Apr-25: 30.0%; May-25: 30.0%; Jun-25: 57.9%
18.	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for adults aged 18 years and over	Jun-25	80%	**99.5%** Above standard	Mar-25: 99.4%; Apr-25: 100.0%; May-25: 100.0%; Jun-25: 99.5%
19	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	Jun-25	65%	**50%** Below standard	Mar-25: 50%; Apr-25: 51%; May-25: 50%; Jun-25: 50%
20.	Median emergency response time to amber calls	Jun-25	12 month reduction trend	**01:34:20** Above standard	Mar-25: 01:46:41; Apr-25: 01:58:55; May-25: 01:19:34; Jun-25: 01:34:20

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
21.	Median time from arrival at an emergency department to triage by a clinician	Jun-25	15 minutes or less	**6** Below standard	Mar-25: 8; Apr-25: 8; May-25: 6; Jun-25: 6
22.	Median time from arrival at an emergency department to assessment by a clinical decision maker	Jun-25	60 minutes or less	**68** Above standard	Mar-25: 64; Apr-25: 63; May-25: 64; Jun-25: 68
23.	Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	Jul-25	Improvement compared to the same month in the previous year, towards the national target of 95%	**65.5%** Below standard	Apr-25: 62.7%; May-25: 63.9%; Jun-25: 61.3%; Jul-25: 65.5%
24.	Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer, or discharge	Jul-25	Reduction compared to the same month in the previous year, towards the national target of zero	**883** Above standard	Apr-25: 887; May-25: 952; Jun-25: 919; Jul-25: 883
25.	Percentage of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Jun-25	12 month improvement trend towards a national target of 80% by 31 March 2026	**67%** Below standard	Mar-25: 68.7%; Apr-25: 59.5%; May-25: 69.6%; Jun-25: 67.0%
26.	Number of patients waiting more than 8 weeks for a specified diagnostic	Jul-25	0	**13,344** Above standard	Apr-25: 14750; May-25: 15177; Jun-25: 14007; Jul-25: 13344
27.	Percentage of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional therapy	Mar-25	100%	**72%** Below standard	Dec-24: 86.24%; Jan-25: 82.00%; Feb-25: 76.66%; Mar-25: 71.58%
28.	Number of patients (all ages) waiting more than 14 weeks for a specified therapy	Jul-25	0	**681** Above standard	Apr-25: 475; May-25: 571; Jun-25: 566; Jul-25: 681
29.	Number of patients (all ages) waiting more than 14 weeks for audiology	Jun-25	0	**679** Above standard	Mar-25: 308; Apr-25: 294; May-25: 456; Jun-25: 679

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
30.	Number of patients waiting more than 52 weeks for a new outpatient appointment	Jul-25	0	**15,505** Above standard	Apr-25: 15949; May-25: 16663; Jun-25: 16172; Jul-25: 15505
31.	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	Jun-25	Reduction compared to the same month in the previous year	**22,503** Below standard	Mar-25: 22227; Apr-25: 21758; May-25: 22853; Jun-25: 22503
32.	Number of patients waiting more than 104 weeks for referral to treatment	Jul-25	0	**1,498** Below standard	Apr-25: 2037; May-25: 2030; Jun-25: 1401; Jul-25: 1498
33.	Number of patients waiting more than 52 weeks for referral to treatment	Jul-25	Month on month reduction towards the national target of zero by 30 June 2025	**33,323** Above standard	Apr-25: 34632; May-25: 35620; Jun-25: 34374; Jul-25: 33323
34.	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	Jun-25	80%	**16%** Below standard	Mar-25: 10%; Apr-25: 14%; May-25: 13%; Jun-25: 16%
35.	Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	Jun-25	80%	**68%** Below standard	Mar-25: 75%; Apr-25: 77%; May-25: 77%; Jun-25: 68%

Report Title:	Board Assurance Framework (BAF): Long Term Financial Sustainability				Agenda Item No:	2.3	
Meeting:	Finance & Performance Committee		Public	x	Meeting Date:	17th September 2025	
			Private				
Status **(please only tick one)**	Assurance	x	Approval		Information/Noting/discussion		x
Lead Executive Title:	Catherine Phillips (Executive Director of Finance)						
Report Author Title:	Andrew Gough (Deputy Director of Finance)						

Main Report
Background and Current Situation:

1. **Purpose**

The purpose of this paper is to discuss and propose the development of a **long-term financial model** for the Health Board.

The model will provide a **clear, evidence-based view of financial sustainability** over a 10 year horizon aligned to the Health Board Strategy and Clinical Services Plan enabling the Board and Executive Team to:

- Understand the trajectory of the Health Board's underlying financial position, taking account of demand, workforce, inflation, and capital requirements.
- Test the impact of different scenarios, including levels of Welsh Government funding, efficiency delivery, and the pace of service transformation.
- Support strategic decision-making, ensuring that clinical service plans, workforce strategies, and capital investments are financially sustainable.
- Prioritise resources effectively, focusing on interventions that have the greatest impact on closing the funding gap and improving outcomes.
- Provide assurance to Welsh Government, Audit Wales, and stakeholders that the Health Board is planning proactively for the future with an evidenced pathway to financial sustainability.

The Health Board is currently under Level 4 Targeted Intervention by Welsh Government, reflecting significant concerns across finance, strategy, quality, clinical services, leadership, and governance. This escalation, confirmed in July 2025, followed deteriorating financial performance, challenges in planned care, fragile clinical services, and cultural and leadership issues.

As part of the response, the Health Board must urgently develop a Clinical Services Plan (CSP) setting out a clear strategic vision for clinical services to 2035. The CSP is a critical requirement for de-escalation and will:

- Address fragile and challenged services.
- Define future models of care across key service groupings: Emergency Care, Planned Care, Children's & Women's, Mental Health, and Regional & Specialised Services.
- Align with national planning expectations and support a financially sustainable Integrated Medium-Term Plan (IMTP).

2. **Background**

- The Health Board has a revenue budget of approximately £2.2bn and is managing significant financial pressures, including an underlying deficit of £59.9m entering the 2025/26 financial year.
- Rising demand, workforce supply challenges, inflationary pressures, and capital requirements are placing increasing strain on sustainability.
- Current financial planning is focused on annual cycles through the IMTP, which does not adequately capture the longer-term financial trajectory.
- Audit Wales have highlighted the importance of robust long-term financial planning as part of system recovery and transformation.
- High level financial and demand modelling has previously been presented at Board Development sessions.

Executive Director Opinion & Key Issues to bring to the attention of the Committee

3. Proposal for Discussion

It is proposed that the Health Board develops a **driver-based, scenario-led long-term financial model** covering a 10 year period.

The model will:

- Integrate financial, workforce, activity, and capital data into a single framework.
- Produce scenarios (base case, optimistic, pessimistic, transformational).
- Be used to test the impact of service redesign, reallocation and distribution of resources, efficiency programs and investment choices.
- Directly inform the IMTP, recovery planning, and capital prioritisation.
- Provide the Board with a transparent and consistent tool to support difficult prioritisation decisions.

4. Potential Challenges

Developing and embedding the model will require the Health Board to address several challenges:

- Data Quality & Consistency: Financial, activity, and workforce data are dispersed across multiple systems and will need validation.
- Assumptions & Uncertainty: Funding settlements, pay awards, demand growth, and service transformation timescales are inherently uncertain.
- Complexity vs. Usability: The model must remain transparent and accessible to non-finance colleagues and the Board.
- Organisational Bandwidth: Dedicated resource will be required to develop the model alongside operational and financial pressures.
- Cultural Adoption: Moving from short-term planning to long-term sustainability requires strong leadership and behavioural change.

5. Organisational Engagement

The model must be owned across the organisation, not just within Finance. Engagement will be required from:

- Clinical Leaders: To model the financial impact of pathway redesign and service strategies.
- Workforce & OD: To provide workforce projections, recruitment pipelines, and agency usage assumptions.
- Planning & Strategy: To align modelling with IMTP priorities and service transformation programmes.

- Estates & Capital Teams: To incorporate capital pipeline, backlog maintenance, and digital investments with associated revenue impacts.
- Executive Team & Board Members: To provide direction, test assumptions, and use the model to guide strategic choices.

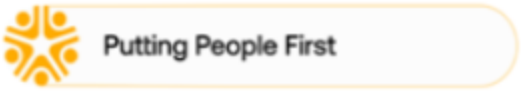
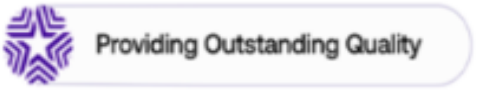
A cross-functional steering group would need to oversee development to ensure ownership and alignment.

Recommendations:

The Committee is requested to:

a) Note and discuss the proposal for developing of a long term financial model aligned to the Health Board Strategy and Clinical Services Plan.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please place an "x" in the below boxes where relevant – *Click each item for further information.*

1. 		2. 	
3. 		4. 	

Five Waves of Working (Sustainable Development Principles) considered:
Please place an "x" in the below boxes where relevant

Prevention		Long Term		Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?
Please place an "x" in the below boxes where relevant

Yes (please include the complete QIA document)		No (please provide reasoning e.g. not required		Enter reasoning here.

Impact Assessment
Please place an "x" in the below boxes where relevant

Risk: Yes/No (delete as appropriate)

Please include the detail of any Risk Assessments undertaken when preparing and considering the content of this report and, where appropriate, the nature of any risks identified. (If this has been addressed in the main body of the report, please confirm)

Safety: Yes/No

Please include the detail of any Risk Assessments undertaken when preparing and considering the content of this report and, where appropriate, the nature of any risks identified. (If this has been addressed in the main body of the report, please confirm)

Financial: Yes/No

Are there any financial implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Workforce: Yes/No

Are there any Workforce implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Legal: Yes/No

Are there any legal implications that arise from the content and proposals contained within this report? If so, has advice been sought and what was the outcome? (If this has been addressed in the main body of the report, please confirm)

Reputational: Yes/No

Are there any reputational risks associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Socio Economic: Yes/No - *Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: https://www.gov.wales/socio-economic-duty-guidance*

The Socio-Economic Duty is to designed to encourage better decision making, ensuring more equal outcomes. Do the proposals within this report contain strategic decisions, such as setting objectives and the development of services. If so has consideration been given to how the proposals can improve inequality of outcome for people who suffer socio-economic disadvantage? Please include detail.

Equality & Health: Yes/No

Equality Health Impact Assessments (EHIA) are typically undertaking when developing or reviewing Health Board strategies, policies, plans, procedures or services. Do the proposals contained within the report necessitate the requirement for an EHIA to be undertaken? If so, please include the detail of any EHIA undertaken or the plans are in place to do so.
(If this has been addressed in the main body of the report, please confirm)

Decarbonisation: Yes/No

There are a number of ways by which carbon emissions can be avoided through the operations of CVUHB.
These include:

- *A focus upon preventing ill health in our population*
- *Saving energy or increasing throughput.*
- *Value based healthcare. Being prudent by not over-treating/intervening. Avoid delivering low-value interventions*
- *Patients empowered to manage their conditions, utilising See on Symptoms and Patient Initiated follow ups to reduce unnecessary outpatient appointments.*
- *Service delivery in the most appropriate setting, e.g. in a community setting rather than an acute setting.*
- *Reducing waste – for example use non-sterile gloves only when needed, manage use-by dates to avoid throwing out good products, recycle and reuse.*

Does the subject matter of your paper risk any of the above not being achieved?

Welsh Language: Yes/No

Consideration should be given to potential impact on the Welsh language, including the following key aspects:
*• **More than just words**: Does the report align with the More than just words strategy, ensuring Welsh-speaking patients can access services in their preferred language, and supporting active offer and bilingual care?*
*• **Accessibility and compliance**: Ensure key information is bilingual and that the report meets the Welsh Language Standards for communication, signage, and patient materials.*

• ***Patient understanding and safety****: Could English-only content impact Welsh speakers' comprehension in critical areas like consent and medication instructions, potentially affecting safety?* • ***Staffing and resources****: Does the report address the need for Welsh-speaking staff or bilingual resources to deliver equitable care?* *Does the subject matter of your paper risk any of the above not being achieved?*

Approval/Scrutiny Route *(please list all other Committees/Groups this report has been to)*	
Name of Committee/Group/Exec	Date:

Report Title:	Outline Business Case for Llantrisant Health Park (LHP) Community Diagnostic Hub (CDH)			Agenda Item no.	3.1
Meeting:	CAVUHB Finance and Performance Committee	Public	x	Meeting Date:	17.09.2025
		Private			
Status *(please tick one only):*	Assurance		Approval	Information	x
Lead Executive:	Catherine Phillips, Executive Director of Finance and Interim Director of Planning				
Report Author (Title):	Victoria Le Grys, Shaping Our Future Clinical Services Programme Director Robert Mahoney, Deputy Director of Finance				

Main Report
Background and current situation:

1.1 In December 2022, CTMUHB submitted a successful business case to the Welsh Government (WG) to purchase the former British Airways Avionics Engineering site at Llantrisant, with the purchase of the site completing in February 2023.

1.2 The vision for the LHP site is to establish a standalone site for high-volume, low-complexity surgical and diagnostic procedures to address capacity shortfalls, meet future demand challenges and support consolidation of services where this will add value to health boards in South East Wales.

LHP will also act an enabler for further regional service reconfiguration. The development of a dedicated facility for planned care, separated from emergency care, was a key commitment in the Welsh Government's recovery document, "Our Programme for transforming and modernising Planned Care and reducing waiting lists in Wales" (April 2022).

1.3 The project is being led by the LHP Project Team at CTM in partnership with ABUHB and CAVUHB. Health Boards in South East Wales have committed to active collaboration where this delivers added value to clinical service delivery, access, and sustainability.

1.4 The development of LHP will be undertaken via a phased approach which has been supported by WG. Phase 1 is the development of a DH. Phase 2a will include a high volume, low complexity orthopaedic inpatient unit. The final Phase 2b, will include a multi-modality day surgery unit. This OBC specifically refers to Phase 1.

2. Specific Matters for Consideration

2.1 The purpose of the Phase 1 LHP OBC is to outline key objectives, current plans for investment and to seek approval for funding from Welsh Government to proceed to Full Business Case (FBC) for the CDH element of the LHP. This OBC supports the improvement of regional access to regional Community Diagnostic services including Radiology (CTMUHB only) and Endoscopy (regional).

2.2 The regional Endoscopy case was submitted and approved by CAVUHB Board in March 2025 alongside the Strategic Case for the LHP.

2.3 The attached OBC sets out the strategic, economic, commercial and financial case for the development. This document is still in draft form on submission to VBRG as work continues at pace to complete it prior to submission to WG.

2.4 The CDH proposal incorporates:

- Imaging capacity – incorporating MRI, CT and NOUS
- Endoscopy capacity – elective and screening services to increase capacity across the region
- Training capacity - working with HEIW, the scheme offers a diagnostic training academy space which links into existing endoscopy suites and provides a base for the endoscopy training academy as well as resources and facilities to support the wider diagnostic training facilities.

2.5 The Phase 1 LHP OBC also includes the development of the wider site infrastructure requirements. This will mitigate the impact on the CDH once operational in regards to later phases of construction (Phases 2a and 2b).

2.6 WG agreed for early submission of the Phase 1 LHP OBC prior to Board approval to enable scrutiny of the OBC to commence without a delay to overall programme timelines. This is critical in ensuring the FBC submission to Welsh Government in December 2025 (following November Board approval).

2.7 The Phase 1 LHP OBC is being presented to CTMUHB Board for approval and to ABUHB and CAVUHB boards for information and not approval. This is because the CDH contract will be held by CTMUHB, CAVUHB and ABUHB will commission activity from this contract and will not be contract holders, but it is critical that both Health Boards support the development.

3. Key Risks / Matters for Escalation

3.1 The key risks are set out in section 4.3 in the attached OBC.

3.2 The key risk currently is the non-approval of the OBC by WG. To mitigate this risk, a thorough approach is being taken to the development of the OBC, supported by robust governance arrangements.

3.3 Final confirmation and support will be subject to the availability of appropriate revenue funding when LHP becomes operational. The level of required revenue funding will be determined by the required demand at that point and the independent provider market costs arising from the tender process which is currently underway.

4. Next Steps

4.1 Subject to Board approval from CTMUHB, the Phase 1 LHP OBC will be submitted to Welsh Government.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

CAVUHB specific assessment of the documents

- **Strategic Alignment:** The LHP aligns to CAVUHB's strategic objectives and regional planning principles.
- **Commissioning Intentions:** CAVUHB Board's endorsed (March 2025) commitment to commission endoscopy capacity from LHP from 2027/28, with a focus on maximising internal efficiencies and workforce planning.
- **Revenue Funding:** Support is contingent on securing additional revenue; this remains a key risk.
- **Workforce Planning:** CAVUHB is committed to maximising internal efficiencies and detailed workforce planning as regional plans develop.

- **Operational Impact:** The CDH will support reduced waiting times and improved patient outcomes for CAVUHB residents.

CAVUHB specific risks and issues

- **Revenue funding risk** (external support required). Therefore, the proposal should be supported in principle whilst a clearer picture of requirements emerge through the tender process.
- **Workforce** transition and sustainability.
- **Ongoing engagement** is required with regional partners and stakeholders including the public on the service redesign.

Recommendation:

The Committee are requested to:

- **Note** the regional planning direction and the OBC for LHP CDH.
- **Note** the CAVUHB's assessment above of the documents and the risks and issues set out above.
- **Support** the submission of the case to Welsh Government following CTMUHB Board approval

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

Putting People First	X	Providing Outstanding Quality	X
Delivering in the Right Places	X	Acting for the Future	X

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention		Long term	x	Integration		Collaboration	x	Involvement	x

Quality Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: Yes

The LHP programme and wider regional portfolio regularly monitor and manage a full risk and issues registers for all programmes and constituent projects

Safety: No

Financial: Yes

Contained within the papers

Workforce: Yes

Contained within the papers

Legal: Yes
To be considered through the regional programme
Reputational: Yes
To be considered through the regional programme
Socio Economic: No
Equality and Health: Yes
Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route:	
Strategic Leadership Team	11.09.25
Value Benefits Realisation Group	08.09.25
Finance and Performance Committee	17.09.25
CAV UHB Board	25.09.25

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Produced on behalf of Cwm Taf Morgannwg UHB by

Archus
The healthcare infrastructure specialist

Outline Business Case
for
Llantrisant Health Park
Community Diagnostic Hub

September 2025

Version 0.7 DRAFT

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SRO	Paul Mears, CEO Cwm Taf Morgannwg University Health Board
Programme Director	Rosie Cavill, Programme Director
Organisation	Cwm Taf Morgannwg University Health Board Cardiff and Vale University Health Board Aneurin Bevan University Health Board

Version control – record of edits

Version	Changes made	By	Date
0.1	Set up template first draft	EH (Ellie Harvey)	25/06/25
0.2	Update with text from Diagnostics Nov 24 business case	BL (Bev Letherby)	30/07/25
0.3	Updated with text from Regional Endoscopy Plan	BL	05/08/25
0.4	Updated with text from Rosie Cavill	RC (Rosie Cavill)	06/08/25
0.4.1	Updated commercial case text and GM comments	BL	14/08/25
0.5	Updated with strategic and commercial case from Elle Beadle	BL	18/08/25
0.6	Updated with Economic Appraisal and Financial Case	HMDK (Henry Mony de Kerloy)	02/09/25
0.7	Reformatted with updated Strategic Case	RC / Archus	03/09/25
0.7b	Final draft for circulation with HB's	RC/Archus	04/09/25
0.7c	Draft with adjusted Exec Summary	RC	05/09/25
0.7d	Draft incorporating CDM comments – issued to WG	CDM/RC	08/09/25
0.7e	Updated with appendices	RC	11/09/25

Appendices

Appendix Ref	Appendix Name
Appendix 1	Strategic Overview Case
Appendix 2	Demand & Capacity Findings
Appendix 3	National Endoscopy Programme Identification of Potential Areas for Regional Centres
Appendix 4	NHS Wales Clinical Skills and Simulation Academy Proposal
Appendix 5	Capital Quantified Risk Register
Appendix 6	Benefits Register
Appendix 7	RIBA 3a Report
Appendix 8	Capital Cost Plan
Appendix 9	Revenue Costs Working Paper
Appendix 10	Comprehensive Investment Appraisal (CIA) Model
Appendix 11	Phase 1 Infrastructure Programme

Glossary

ABUHB	Aneurin Bevan University Health Board
BAU	Business As Usual
BCR	Benefit Cost Ratio
BfW	Building for Wales
BIM	Building Information Modelling
BREEAM	Building Research Establishment Environmental Assessment Method
CDE	Common Data Environment
CDH	Community Diagnostic Hub
CIA	Comprehensive Investment Appraisal
CIA	Comprehensive Investment Appraisal
CSF	Critical success factor
CTMUHB	Cwm Taf University Health Board
C&VUHB	Cardiff and Vale University Health Board
DHSC	Department of Health and Social Care
FBC	Full Business Case
GiRFT	Get it Right First Time
HB	Health Board
IIB	Infrastructure Investment Board (Welsh Government strategic committee)
ISP	Independent Service Provider
MMC	Modern Methods of Construction
NEC	New Engineering Contract
NPC	Net Present Cost
NPSV	Net Present Social Value
NWSSP – SES	NHS Wales Shared Services Partnership - Specialist Estates Services
NZC	Net Zero Carbon
BJC	Business Justification Case
OBC	Outline Business Case
PM	Project Manager / Programme Manager / Project Management
PSC	Professional Services Contract
PWF	Preferred Way Forward
RPA	Risk Potential Assessment
SAB	SuDS Approval Body
SCP	Supply Chain Partner
SO	Spending Objective
SOC	Strategic Outline Case
SRO	Senior Responsible Officer
WG	Welsh Government

1 Executive summary

1.1 Structure and introduction

The purpose of this outline business case (OBC) is to outline key objectives, current plans for investment and seek approval for funding of **£2.177M** from Welsh Government to proceed from OBC approval to full business case (FBC) approval for the Phase 1 of the Llantrisant Health Park (LHP) Programme which comprises the Community Diagnostic Hub (CDH) and site wide infrastructure works to prepare for later phases.

The project is being led by the LHP Project Team at Cwm Taf Morgannwg University Health Board (CTMUHB) in partnership with Aneurin Bevan University Health Board (ABUHB) and Cardiff and Vale University Health Board (C&VUHB). Health Boards in South East Wales have committed to active collaboration where this delivers added value to clinical service delivery, access, and sustainability, as it does for this scheme.

This OBC supports the first priority, to improve access to regional Community Diagnostic services including Radiology and Endoscopy. Business cases for later phases of this development including Orthopaedic Surgery with supporting ward accommodation and Day Surgery will be prepared as later phases in the programme.

The structure of the OBC is outlined in the table below.

Case	Section / Purpose		Description
Strategic	2	Strategic Context	Provides an overview of current services and explains how the project is strategically placed to contribute to the delivery of organisational goals.
	3	Case for Change	Establishes the case for change by outlining the spending objectives, existing arrangements and business needs.
	4	Potential Scope and Services	Identifies the potential scope of the project in terms of the operational capabilities and service changes required to satisfy the identified business needs.
	5	Benefits and Risks	Identifies the benefits, risks, constraints and dependencies for the project.
Economic	6	Options Identification and Appraisal	Explores the preferred way forward by agreeing critical success factors (CSFs), determining the longlist of options, and undertaking a SWOT analysis to identify a shortlist of options.
	7	Economic Appraisal	Appraises the economic costs, benefits and risks for the short-listed options and concludes which option represents the best value for money.
Commercial	8	Procurement Route, Scope and Contractual Details	Outlines: • the procurement strategy and routes that have been agreed. • the scope of the procurement • the contractual arrangements of the potential deal to deliver the recommended solution for the project.
Finance	9	Financial Appraisal	Sets out the forecast financial implications of the preferred option.
Management	10	Management Arrangements	Sets out the arrangements put in place to manage the project to successful delivery.

1.2 Background and context

During autumn 2022, Cwm Taf Morgannwg University Health Board (CTMUHB) became aware of the intention of British Airways Avionics Engineering (BAAE) to sell the long leasehold on their former engineering site in Llantrisant. The site was vacant, as BAAE had relocated their service provision to St Athan during early 2022 (but remained as tenants of the site).

The total site covers over 20 acres with a developed area that comprised three separate buildings totalling over 10,300sqm and includes on site parking for around 300 cars. The site has the potential capacity and infrastructure for a wide range of clinical services. There is also an area of cleared ground that is available for further on-site development.

In December 2022 CTMUHB submitted a case to Welsh Government (WG) to request funding for the purchase of the site, which was to be known as Llantrisant Health Park (LHP). This case set out the initial development aims and aspirations and was approved by CTMUHB Bard. WG approved the purchase and released £8M funding for the purchase of the site on the condition that the development was for a regional health facility for the South East Wales Region. The purchase completed in February 2023.

The vision for LHP is to establish a standalone site for high-volume, low-complexity surgical and diagnostic procedures to address capacity shortfalls, meet future demand challenges and support consolidation of services where this will add value to participating health boards. LHP will also act an enabler for further regional service reconfiguration. The development of a dedicated facility for planned care, separated from emergency care, was a key commitment in the Welsh Government's recovery document, *Our Programme for transforming and modernising Planned Care and reducing waiting lists in Wales* (April 2022).

The need to introduce diagnostic and treatment capacity to the South East Wales region has never been greater. Since the COVID-19 pandemic, waiting lists have increased to their highest ever levels and Health Boards have struggled to address this within existing capacity and working practices. Set alongside this is the increasing aging population and acute medicine pressures which indicate that a significant change to current practice and how we use our existing infrastructure is essential if performance and access to treatment is to be improved.

LHP offers the region a unique opportunity to deliver new ring-fenced elective capacity, encompassing innovative developments and state of the art practice. The site will provide efficient and proven effective models of care to deliver increased diagnostic and treatment facilities across the region.

The CDH proposal incorporates:

- **Imaging capacity** – incorporating MRI, CT and ultrasound as part of a Community Diagnostic Hub (CDH). The unit will also have the capability to deliver plain film X ray
- **Endoscopy capacity** – elective and screening services to increase capacity across the region and address the projected six suite shortfall across the region by 2027/28 and to introduce a training academy to respond to workforce shortfalls.
- **Training capacity** - working with HEIW, the scheme offers a diagnostic training academy space which links into existing endoscopy suites and provides a base for the endoscopy training academy as well as resources and facilities to support the wider diagnostic training facilities.

This OBC seeks approval to progress to Full Business Case (FBC) for phase 1 of the LHP Programme. To develop a CDH and undertake site infrastructure works to mitigate impact on the operational CDH during later phases of construction,

As well as phase 1, the LHP Programme consists of the following phases which will be subject to separate business cases:

- **Phase 2 - High-volume, low-complexity orthopaedic inpatient unit** - providing capacity for up to six theatres to deliver arthroplasty (knees and hips) surgery for patients meeting the criteria for treatment without critical care support. An inpatient unit adjacent to the theatres will accommodate patients requiring an overnight stay.
- **Phase 3 - Multi-modality day surgery unit** – principally focused on addressing the significant shortfall in dedicated day surgery capacity across CTMUHB, it will be a dedicated and fully efficient centre of excellence that reduces wait times.

Whilst capital funding will be applied for all phases to design and build the units, the plan for the CDH is that the service will be provided by an independent service provider (ISP) under a managed service contract for an initial 7 year term, which can be extended for up to 3 years on a year by year basis. The ISP will equip and staff the unit. The procurement for the ISP is currently ongoing with a preferred supplier proposed to be selected by the end of September and an appointed confirmed by the end of October.

CTMUHB is the lead party in the procurement and will be the contracting party for the managed service contract with the ISP. The OBC is based on the fact that there is agreement that both C&VUHB and ABUHB will contract for endoscopy services only from the CDH in line with the outputs from the regional planning exercise recently undertaken. The imaging provision initially will be contracted for CTMUHB for their patients only. ABUHB has stated that it may look to commission imaging services from LHP in the future.

It is recognised that Health Boards have obligations in respect of public engagement and consultation when introducing significant service changes, and these will have some application when progressing a model of regionally based provision of elective and diagnostic services.

The principle of patients travelling further to access more timely care has been tested in a regional context with a recent engagement exercise for cataract surgery, when positive feedback was received from both public and Llais. Close contact with Llais will be maintained as the LHP plans progress, to ensure that the required arrangements are in place and that any concerns / issues arising are addressed and mitigated as appropriate.

1.3 Vision and spending objectives

The vision of the LHP programme is to create a standalone site for high volume low complexity surgery and diagnostics that guarantees uninterrupted, effective, efficient services, which address both current capacity shortfalls and offers opportunity to meet future demand growth. Phase 1 will deliver the diagnostic element of the programme and enable the future phases on the site.

The spending objectives listed in the table below were agreed by members of the LHP Programme Board in September 2024 as overriding programme objectives which have been adapted to apply directly to this phase 1.

Ref	Theme	Spending objective	Benefit
SO1	Meet population needs	The delivery of an elective high volume low acuity model of care for the South East Wales Region on a phased basis. The first phase to focus on diagnostics and endoscopy. A second and third phase to focus on orthopaedics and day surgery respectively. Phase 1 services to be operational during the 2027/28 financial year. Future phases to consider further regional services such as pathology.	• Right-sized to meet current and future demand • Improves access to range of services • Centre of Excellence with efficient service delivery models and improved patient outcomes and increased throughput • Able to flex for the future
SO2	Maximise capacity	To maximise clinical capacity on the LHP site. To ensure that the maximum amount of available space is directed towards direct service delivery with supporting services managed from the neighbouring Royal Glamorgan site.	• Creates opportunities for centralisation of skillsets; centre of excellence • Enables greater collaboration regionally • Creates opportunity for one stop diagnostics, improved use of resources and appointments
SO3	Innovation and standardisation	To facilitate and support the use of innovative design and delivery solutions in both clinical and non-clinical services. To implement standardised protocols and practices to promote efficient service delivery offering improved value for money and addressing the modifiable drivers of increased cost against English Tariff, excluding those aspects driven by Welsh Policy.	• Standardisation of consumables, with financial savings • Standardisation of best practice/policies; efficiencies, increased throughput, reduction of wait lists
SO4	Enable training / development of future workforce	To enable increased training and development of secondary care staff including accommodating more medical trainees and students.	• Accommodates placements for students (allowing role development and succession planning) • Improved workforce retention and recruitment
SO5	LHP Models of Care and Workforce Models	During phase 1 to ensure that the managed service provider delivers compliant and innovative models of care and workforce models, following the initial terms to develop innovative and new models of care to bring the CDH back into NHS management and control. . In Phases 2 and 3 to develop a new model of care and workforce models to support the delivery of the core services, the models will support efficient delivery of services	• Environment / ways of working that support staff welfare and wellbeing • Improved skills and job satisfaction • Improved patient outcomes • Multi-disciplinary working

Ref	Theme	Spending objective	Benefit
SO6	Sustainable estate	To deliver a sustainable infrastructure on the site maximising decarbonisation and net zero opportunities.	• Complies with relevant standards; NZC, BREEAM excellent and energy performance • Opportunities for future additional service provision for South East Wales. • Opportunities for further regional reconfiguration and enabling of service and or estate rationalisation.

1.4 Case for change

NHS diagnostic services remain under significant pressure despite concerted endeavours of health boards to increase capacity and improve access to reduce waiting times.

The *Diagnostics Recovery and Transformation Strategy for Wales 2022-2025* sets out the plan to improve, transform and redesign diagnostic pathways in Wales. This national strategy seeks to deliver on the following aims:

- Improving outcomes and reducing pressure on secondary care.
- Addressing unmet care need that has been exacerbated by COVID-19.
- Enabling people to live longer, healthier lives at home.
- Identifying treatments earlier in disease which enables intervention and care management more rapidly.
- Creating a sustainable and intelligent integrated health system which reduces inequality.
- Making Wales a great place to live and work.

The South East Wales Regional Diagnostics plan for Community Diagnostic Hubs aligns with this strategy and its aims through the intention to seek both a rapid expansion of diagnostic service access and the delivery of new models of care with a focus on providing centres of excellence which will attract and retain the required workforce. Alongside this the Hub will align with GiRFT and JAG principles in promoting best practice.

Radiology

Radiology forms part of the 26 week **referral to treatment time** target (RTT) and 62 day single cancer pathway target, from suspicion to first definitive treatment It is also anticipated that with increased capacity and significantly reduced waiting times there will further opportunity to gain efficiencies across the health system by developing clinical pathways that incorporate diagnostics at an earlier stage, aiming to reduce pressures on services and improve the patient experience.

Radiology demand and capacity modelling has focused on the CTMUHB position only. The current waiting times are as set out below:

Date	Non Cardiac CT		Non-Cardiac MRI		Non Obstetric USS		Total	
	<8 weeks	>8 weeks	<8 weeks	>8 weeks	<8 weeks	>8 weeks	<8 weeks	>8 weeks
Jan-24	1,716	966	1,765	1,166	2,685	3,427	**6,166**	**5,559**
Jun-25	2,154	994	1,964	33	3,483	1771	**7,601**	**2,798**

The number of patients waiting within CTMUHB has increased in the last 15 months. This is despite the use of non recurrent funding to provide interim and additional temporary capacity such as the siting of a mobile MR and CT on the LHP site. This has significantly reduced the over 8 week waits but has not reduced the total number of patients waiting.

When considering the actual imaging capacity within CTMUHB to projected demand there is a clear ongoing shortfall in capacity and without additional intervention waiting times will continue to increase. As part of the regional imaging planning processes, all organisations have been looking at whether they can maximise utilisation of existing assets by extending working days and hours.

Modality	Potential capacity	Forecast	2026/27	2027/28	2028/29	2029/30	2030/31
MRI	**30,087**	Demand	27,729	29,947	32,343	34,931	37,725
		Variance [1]	*2,358*	*140*	*-2,256*	*-4,844*	*-7,638*
CT	**100,512**	Demand	90,013	94,514	99,239	116,250	126,596
		Variance	*10,499*	*5,998*	*1,273*	*-15,736*	*-26,084*
Ultrasound	**80,484**	Demand	45,519	47,794	50,184	52,693	55,328
		Variance	*34,965*	*32,690*	*30,300*	*27,791*	*25,156*

By maximising capacity in the short term CTMUHB can continue to meet demand in all modalities until the end of 2027/28. From 28/29 shortfalls in MRI and CT start to become apparent. LHP is due to open in late summer 2027/28 so will be in place to meet the shortfalls within CTM. However this does not account for CTMs ability to be able to recruit suitable workforce or the level of resource required to secure this level of service. Whilst MRI and CT capacity can be increased to mitigate demand growth additional capacity will still be required from LHP.

On the face of it, CTMUHB has potential capacity to meet ultrasound demand over the next five years and beyond, however NOUS services are under extreme pressure on all sites within CTMUHB and are recognised as being a service under pressure nationally in Wales. Much is due to the high workforce input into this modality which leads to strains on the existing resource and sees higher levels of sickness and rest breaks generally required by sonographers.

The deliverability of the potential capacity levels for NOUS are not realisable due to two important drivers due to the high demand for obstetric scanning coming from the changes in the care pathways and the ergonomic challenges of the patient group which is resulting in increased sickness and RSI issues within the workforce and driving down productivity.

- Firstly, changes to antenatal care pathways are driving an increase in obstetric scanning and this must be prioritised over elective scanning, due to the shorter timescales.
- Secondly, due to the volume of obstetric scanning and ergonomic challenges of our patient group, we are seeing increased sickness driven by RSI issues which is further limiting the actual capacity.

The provision of a standalone service, provided by a workforce distinct to our obstetric services is critical to deliver NOUS waiting times and provide ringfenced service whilst existing capacity can be focused on achieving obstetric scanning demand. It is clear that alongside increases to existing asset hours of operation the services at LHP will be critical to deliver a sustainable diagnostic performance.

[1] Surplus / shortfall

Endoscopy

Despite significant work undertaken by the three health boards in the South East Wales region, the performance profile currently indicates a significant proportion of patients waiting more than the target waiting time of accessing diagnostic endoscopy within eight weeks. In August 2024 there were nearly 8,000 patients waiting more than eight weeks for a diagnostic endoscopy, although this position has improved because of additional non-recurrent funding.

The demand and capacity model developed by the National Endoscopy Programme for Wales (NEP), has identified a recurrent shortfall in capacity. This demand is driven by increasing symptomatic demand coupled with the phased extension of the age range for Bowel Screening. The outcomes of this modelling work confirmed a six-room shortfall in the South Wales region by 2027/28 and recommended the introduction of a JAG compliant standalone regional endoscopy unit.

Regional planning teams have developed integrated plans to address the resultant capacity shortfall of six rooms. Local plans and capacity increases will meet some of the demand leaving a four-room operational shortfall to be met by LHP from 2027/28. In addition, there is a desire to create at least one training room which would equate to a requirement of five rooms at LHP. The current design incorporates six endoscopy rooms and associated supporting space. This provides a sustainable and resilient approach to the development; it enables the absorption of future growth or changes in screening requirements by Public Health Wales as well as offering training opportunities and resilience in case of down time in any room.

This OBC focuses on the delivery and resources associated with the LHP site only. Any further resources required to support local plans will be developed further through the regional planning process.

1.5 Economic Case

1.5.1 Clinical service delivery options

In determining the case to support regional CDHs in South East Wales, the Regional Diagnostic Board led an exercise to consider how HB could deliver improved performance in diagnostics. The criteria agreed for the option appraisal were:

- Strategic viability (does it fit with the local and regional plans?)
- Does this option meet the service demand requirements?
- Will this deliver sustainable diagnostic services?
- Clinical viability (can the option deliver the procedures included in the service specification?)
- Operational viability (can this be operational within project timeframes?)
- Workforce viability: does this option:
  - Support sustainable workforce?
  - Facilitate training?
  - Deliver on national strategy?
  - Have implications for existing workforce?
- Estates viability (would this option facilitate the appropriate spaces, e.g. clinic rooms and outpatients space?)
- Financial viability (are the revenue and capital costs reasonable?)
- Geographic suitability / accessibility.

In the first instance regional HBs developed an options longlist for improvement of access to regional diagnostic services against the evaluation criteria.

During 2023, this long list was reviewed collaboratively through the clinical and operational leads group against an agreed set of criteria and subsequently tested by each health board prior to consideration by project and programme boards.

The options considered by the regional Project Board are set out below.

Option 1	**Do nothing** - Health boards would continue to provide services as per current arrangements.
Option 1a	**Different approach to the use of existing services** in each health board, and work toward collaboration through shared processes. Health board expansion of internal capacity and/or other forms of regional working.
Option 2	**Independent Community Diagnostic Hubs (CDH)** – each health board operating their own CDH with no cross-border treatments.
Option 3	**Regional Community Diagnostic Hubs** – a minimum of one per health board, delivering cross-border diagnostic treatment.
Option 4	**A single Regional Radiology Diagnostic centre**, located on one site, serving all three health boards.
Option 5	**Combined approach** - Regional Diagnostic Centre/community diagnostic hubs.
Option 6	**Community Diagnostic Hub with Mobile Units** – as option 3 but with mobile units attached to reach outlying communities through community diagnostic clinics.

Assessment by the clinical and operational leads resulted in a short-list of model options for consideration by the Project Board. The shortlist included three options:

- **1a** – different approach to the use of existing services
- **3** – Community diagnostic hubs (CDH) with a minimum of one per health board area, and
- **6** – Community diagnostic hubs with the option of mobile units.

The Project Board considered these options formally on 23 January 2024 and confirmed the acceptability of both **Option 3** and **Option 6** with the preferred option of development of a community diagnostic hub model for the region, which may incorporate mobile units, as required.

1.5.2 Site and infrastructure delivery options

The purpose of the Options Analysis is to identify and appraise the options for the delivery of project and to recommend the option that is most likely to offer best value for money.

However, in this instance this section will not undertake a traditional options appraisal using the business case framework, which is an approach that has been agreed with colleagues in the Capital and Estates team in Welsh Government (WG).

This is due to the fact the purchase of the LHP site was approved and funded by WG in December 2022 on the condition the funding was used to develop the site as part of a regional approach to the delivery of services. Therefore, consideration of alternative site options is not relevant.

The services included at this business case stage are the same as those included in the original case for the purchase of the site, with some small changes to the numbers of the same, in line with demand and capacity modelling provided in Section 3 of this case.

As a result, this section will not consider alternative options for service change with the scope and scale having been proven in the sections above. In addition, following WG approvals, design work has already progressed beyond the traditional stage for an OBC, with WG approval to proceed to RIBA 3 given in December 2024.

The RIBA 2 design work was subject to scrutiny by Shared Services Specialist Estates and considered only the **preferred new build infrastructure option**. Scrutiny on the RIBA 2 phase closed on 18 December and approval to proceed to RIBA 3 was given on that date. In addition funding has been provided for the demolition of the buildings on the site which is due to complete in September 2025. As a result, there is no scope to further consider infrastructure and build options.

Finally, a main contractor for completion of the design phase was appointed on 28 March 2025. The tender process demonstrated a modular form of MMC was preferred and WG approval to enter into the design contract was received on 14 March 2025. As a result, the build methodology has also been fully determined. Therefore, the economic appraisal in following sections will focus on the delivery options for the CDH only in terms of the scope of the agreement with the third party provider.

1.5.3 Summary of Phase 1 service delivery options

Whilst the decision has been made to appoint an independent service provider to deliver the model in the CDH, there are options about the extent to which this can be delivered by the partner. As a result, this has been the focus of a more detailed option appraisal with the key options being:

Components	**Option 1 -** Fully outsourced managed service contract	**Option 2** (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	**Option 3 -** Traditional capital build and equip + ISP deliver services via managed service contract	**Option 4 -** Traditional capital build and equip + NHS staffing and service provision
Building	ISP Design and Build (Costs captured through revenue costs)	NHS Design and Build (WG Capital Funding)	NHS Design and Build (WG Capital Funding)	NHS Design and Build (WG Capital Funding)
General Building Equipment	ISP Design and Build (Costs captured through revenue costs)	NHS Design and Build (WG Capital Funding)	NHS Design and Build (WG Capital Funding)	NHS Design and Build (WG Capital Funding)
Specific Service Delivery Equipment – First 10 Years after completion of LHP	ISP provide and maintain (Costs captured through revenue costs)	ISP provide and maintain (Costs captured through revenue costs)	NHS Provide and Maintain (WG Capital Funding)	NHS Provide and Maintain (WG Capital Funding)
Specific Service Delivery Equipment – After 10 years	NHS Provide and Maintain (WG Capital Funding)	NHS Provide and Maintain (WG Capital Funding)	NHS Provide and Maintain (WG Capital Funding)	NHS Provide and Maintain (WG Capital Funding)
Service Delivery (Staffing) – First 10 Years after completion of LHP	ISP Staffing	ISP Staffing	ISP Staffing	NHS Staffing
Service Delivery (Staffing) – After 10 Years	NHS Staffing	NHS Staffing	NHS Staffing	NHS Staffing
Lifecycle Costs – First 10 Years after completion of LHP	N/A	Building Lifecycle Costs	Building Lifecycle Costs	Building Lifecycle Costs

Components	**Option 1 -** Fully outsourced managed service contract	**Option 2** (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	**Option 3 -** Traditional capital build and equip + ISP deliver services via managed service contract	**Option 4 -** Traditional capital build and equip + NHS staffing and service provision
Lifecycle Costs – After 10 years	NHS (WG Capital Funding) buys building buy back at net book value after 10 years. Building Lifecycle and equipment replacement Costs	Building Lifecycle and equipment replacement Costs	Building Lifecycle and equipment replacement Costs	Building Lifecycle and equipment replacement Costs

1.5.4 Economic Appraisal

An economic appraisal was prepared, in line with HM Treasury Green Book guidance, to evaluate the whole life costs, benefits and risks of the shortlisted options in order to identify the option that is most likely to offer best public value for money.

The results of the economic appraisal demonstrate that the preferred way forward offers value for public money.

Option 2 (preferred option), which utilises a traditional capital for the build of phase 1 of the LHP (the Community Diagnostics Hub portion), with an ISP providing the service provision equipment and delivering the service via a managed service contract for up to 10 years before the service becomes inhouse and run by the Health Boards, (7 years initial contract with up to 3 1 year extensions on the same), will require capital investment of £109.1m and ongoing revenue costs of £7.5m (excluding depreciation) for the initial 10 year period of the managed services contract, reducing to £5.4m after the end of the contract. Based on estimated costs and benefits, it is anticipated that this option will deliver an incremental Net Present Social Value (NPSV) of £38.9m and a Benefit Cost Ratio (BCR) of 1.13. It should be noted that this relates to the capital and revenue element of CDH only, to realise regional plans for diagnostic, additional revenue investment is also required on other UHB sites.

This represents £1.13 of incremental benefit delivered for every £1.00 of incremental whole life cost, because of the quantifiable benefits that it has been possible to state in monetary values at this point in time, including:

- **Improved patient outcomes from earlier diagnosis:** Delivery of the CDC will address CTMUHB Diagnostic Imaging and regional Endoscopy capacity shortfalls and ensure future demand can be met. This will have a direct impact on waiting times for patients and support the cancer pathway by enabling earlier diagnosis, more targeted interventions and improved monitoring. This will lead directly to delivering better patient outcomes, specifically contributing to improved cancer survival rates.
- **Improved patient outcomes from earlier diagnosis (non-cancer related)**: Delivery of a significant increase in additional Endoscopy capacity should lead to earlier and increased diagnosis for patients with health issues other than cancer such as hypertension, which will lead to better patient outcomes and help contribute to reduced mortality related to those health issues.

In addition to this, there are other quantifiable benefits which it has not yet been possible to state in monetary values given the information that is available at this time. These will be explored further at FBC stage and, it is expected, will further strengthen the BCR. These include:

- **Release of elective diagnostic capacity at Acute sites, which can be used for urgent and emergency care patients/pathways:** The capacity provided at LHP for more elective diagnostic tests will free up Acute sites to use their diagnostic capacity for non-elective scans/tests, which reduce delays for urgent and emergency patients.
- **Improved predictability and confidence in booking scans and tests:** The centralised elective centre with co-located services provides a 'one-stop' shop clinic with greater predictability of care which in turn means that scans and tests can be booked with more confidence leading to improved utilisation of the service.
- **Impact of a more sustainable estate:** The delivery of appropriately designed and compliant facilities provides opportunities to contribute to CTMUHB's environmentally sustainable goals and national strategies around decarbonisation and optimising energy efficiency. The transformed model of care with its standardised pathway is likely to make it easier to implement and maintain sustainability programmes that CTMUHB has instituted in other areas, such as reducing waste and single use products.

LHP will also deliver various non-financial benefits which while they cannot be quantified in monetary terms are equally important to the delivery of local, regional and national policy. These include:

- **Additional Imaging and Endoscopy capacity leading to reduced waiting times:** The additional capacity at LHP will allow the Health Boards to meet the NHS Wales target that no patient is waiting more than 8 weeks for imaging or endoscopy tests.
- **Help to meet 'Straight to Test Guidance':** The additional capacity provided at LHP will assist with meeting 'Straight to Test Guidance', allowing an increase in the number of direct referrals from GPs to radiology. It will also allow for improved regional sustainability and provide contingency for other sites across the region.
- **Increased number of and improved clinical pathways:** Due to LHP being a centralised elective centre and a "one-stop" clinic, it will lend itself to developing and delivering more and improved clinical pathways. These pathways and improved ways of working could be used as an exemplar and then also be rolled out across the region.
- **Reduced health inequalities:** Reduction in waiting times and ease of access supports equality of access.
- **Community Benefits:** The contractor has agreed to implementing several community benefits, including hiring local, providing volunteering and donations to local organisations, investing in people learning and using Welsh and investing in the local supply chain.
- **Improved patient experience:** As well as reduced waiting times patient experience is enhanced by the modern fit for purpose facilities and the ease of access the location of LHP offers, with its good road links and parking. Having a centralised elective centre with co-located services provides the convenience of a ***one-stop shop*** clinic with greater predictability of care.
- **Increased staff satisfaction:** The improved training pathway and increased training opportunities, along with the modern fit for purpose facilities and a consolidated service model that enables more effective ways of working, contributes to staff satisfaction and creates an attractive place to work which will support recruitment and retention of highly trained health professionals in the long term.
- **Develop a skilled endoscopy workforce:** Delivery of the Skills Academy in partnership with HEIW will provide significant opportunities to increase the number of training places available in the region and help to build a skilled and sustainable endoscopy workforce.
- **Increased compliance:** The dedicated CDC will ensure that the Health Boards have capacity across the region to ensure alignment with GiRFT principles and continue to achieve JAG accreditation. Modern fit for purpose facilities that are compliant with WHBNs and HTNs, achieve BREEAM rating of Excellent.

- **Future proofing:** The site also provides a level of future proofing by providing expansion space that offers opportunities for other future developments.
- **Opportunities for future transformation:** The additional capacity offered by LHP provides opportunities to transform and reconfigure core local services and deliver things differently in the future. Further to this the robust and in-depth data/reporting the service at LHP will provide to the Health Boards will greatly inform future decisions. The successful delivery of a regional centre will also provide proof of concept as the basis for the development of any future regional pathways and will have a positive reputational effect.

The results of the options appraisal (excluding BAU) are presented in the table below.

Element	**Option 1 -** Fully outsourced managed service contract	**Option 2 (PWF) -** Traditional capital build + ISP equip and deliver services via managed service contract	**Option 3 -** Traditional capital build and equip + ISP deliver services via managed service contract	**Option 4 -** Traditional capital build and equip + NHS staffing and service provision
Initial capital investment	£0m	£109.1m	£119.7m	£119.7m
Incremental NPSV	**-£10.8m**	**£39.9m**	**£24.9m**	**£16.5m**
Benefit Cost Ratio	**0.97**	**1.13**	**1.08**	**1.05**
Key benefits	As per benefits outlined above for the Preferred Option	As per benefits outlined above for the Preferred Option	As per benefits outlined above for the Preferred Option	As per benefits outlined above for the Preferred Option
Key risks	• Unable to secure a service provider who would be willing to provide the service • Unable to secure revenue funding • Implementation is delayed due to increased procurement timescales • Significant risks around handover of the building at the end of the managed service contract period, including higher than expected handover costs and that the building would not fully meet the Health Boards requirements.	• Significant initial capital outlay • Unable to secure revenue funding	• Significant initial capital outlay • Unable to secure revenue funding • Implementation is delayed due to increased procurement timescales	• Significant initial capital outlay • Unable to secure revenue funding • Implementation is delayed due to increased procurement timescales • Unable to recruit sufficient staff to enable delivery of the model in the short term

It should be noted that this assessment is based on an initial assessment of benefits and risks and further work is required to quantify these more fully. As outlined above, it is anticipated that this is likely to further strengthen the BCR and value for money case as the scheme progresses to FBC stage.

1.6 Commercial Case

To maintain momentum within the programme, the main contractor was appointed during RIBA 3 for continued development of the design and construction elements. This ensures the contractor is involved in the more detailed design incorporating the latest technology and identifying programme opportunities. The appointment was made via the Crown Commercial Services Framework which offered the opportunity to tender for both traditional and modern methods of construction. WG approved the appointment which was made in March 2025.

In addition, the contractor will be critical for SAB and planning applications to ensure that the approved design does not require further planning amendments, which could delay the programme.

WG also approved early site wide demolitions in January 2025. These have been delivered by a contractor appointed under the Crown Commercial Framework. Works commenced on 14 April and are due to complete by 20 September 2025.

WG have approved funding for the whole programme up to the end of RIBA 3 and have recently approved a further £2.828M to support the completion of a phased RIBA 1 OBC and to commence RIBA 4 works (which will include the redesign necessary for Phase 1 to be fully standalone. This funding will cover works up to OBC approval, but further funding of £2.177M will be required to complete RIBA 4 on OBC approval.

Should a decision be made not to complete RIBA 4 following the outcome of this business case then there is a risk of a contractor claim against the Health Board under the PSC contract.

The phased approach will increase design stage fees over and above those in the original tender however this will be covered more in the Phase 2 OBC. Tendered fees will cover Phase1.

1.6.1 Independent Service Provider (ISP) procurement

CTMUHB, acting on behalf of the three Health Boards in South East Wales is currently undertaking a procurement exercise to appoint a prime contractor to act as a design partner and contributor to the pathway redesign currently being scoped out for diagnostic services to provide one imaging CDH with the option to flex to one further CDH over the course of the contract. In addition, the CDH will also have at the same location, an ISP staffed Endoscopy Suite comprising of up to four rooms co-located with an NHS staffed two room Endoscopy Training Academy. The endoscopy suite requirements will be designed and fitted out to meet JAG accreditation standards.

There will be a co-located training academy which will include an endoscopy theatre. It is expected that the fitting out of the academy training rooms, and delivery of activity will be facilitated by NHS organisations through collaborative work with Health Education and Improvement Wales.

The Regional Radiology Project Board and the Regional Diagnostics Programme Board endorsed the use of competitive dialogue to test the market potential to support the development of a regional diagnostic centre and associated community diagnostic hubs, one of which will be on the LHP site. The competitive dialogue procedure is flexible and allows the Procurement Evaluation team to discuss proposed solutions with bidders to understand advantages and disadvantages.

The recommended option is to develop a regional endoscopy centre through a traditional NHS capital build proposal and to seek the equipment and delivery of the centre activity through contract with a commercial partner.

To drive this strategy, further competitive dialogue will need to be completed to understand financial implications and other non-financial risks. The current procurement programme leads to the appointment of the ISP by the end of October 2025.

1.7 Financial Case

The financial analysis demonstrates that delivery of the preferred way forward is affordable providing that Welsh Government capital funding can be secured, and agreement reached with commissioners about revenue funding requirements.

1.7.1 Capital affordability

The cost plan prepared by CTMUHB's Cost Advisors, based on RIBA 3a design, estimates that delivery of LHP will result in capital investment requirements of £110.0m in total, including expenditure incurred to date. It is anticipated that this will be funded by Welsh Government as follows:

Funding of £18.1m had been received to date from WG for:

- Site purchase - £8.0m
- RIBA 2 fees - £3.1m
- RIBA 3 fees - £3.5m
- Demolition - £0.7m
- RIBA 4 fees - £2.8m.

This includes funding of £2.828m which has been approved in August 2025 to support the Phase 1 OBC redesign and the commencement of RIBA 4 works to support the FBC being completed for November boards.

Further funding of £2.771M is sought from this OBC to enable the Health Board to deliver an FBC and continue progress through RIBA 4 and 5 stages to be ready to commence with on-site works on FBC approval.

This forms part of the total additional funding of £91.9m which will be required to deliver the Phase 1 CDH and supporting site wide infrastructure works following approval of the FBC.

1.7.2 Revenue affordability

Work undertaken to date by the programme team and finance leads estimates that provision of services at LHP will incur recurring revenue costs of £9.3m for contracted out services for MRI, CT, NOUS, and Endoscopy.

It is expected that the contract value will be reduced through the agreement of a tariff discount in return for the ISP's use of land and buildings. This has been estimated for the purposes of the OBC at £1.9m per year.

These indicative costs are based on high level assumptions at this stage and will be firmed up at FBC stage once more detailed information is available and the preferred ISP partner has been identified following the final stage of the tender.

This therefore results in a recurring revenue funding requirement of £7.5m. This has been allocated across the three Health Boards, based on projected activity assumptions which have been identified at this time, which equates to the following:

- CTMUHB £6.0m p.a. (£4.8m after the proposed tariff discount)
- C&VUHB £2.7m p.a. (£2.2m after the proposed tariff discount)
- ABUHB £0.7m p.a. (£0.5m after the proposed tariff discount).

These requirements reflect each Health Boards current position to commission the following services from LHP. ABUHB half an endoscopy room, Cardiff and Vale UHB 1.7 endoscopy rooms and CTMUHB will commission endoscopy and imaging services comprising CT, MRI and ultrasound.

For both ABUHB and C&VUHB their commissioning intentions for endoscopy reflect the outcomes from the regional endoscopy planning exercise that has been undertaken. Part of the planning identified several measures to meet un-met demand in endoscopy services and it should be noted

that the revenue contributions contained in this case only reflect the costs of services provided at LHP. Health Boards will incur further revenue costs in delivering additional diagnostic activity and these will be covered in separate business cases.

It should be noted that these cost and activity levels remain subject to change during the procurement and contracting process and should activity levels being commissioned change as will costs.

1.8 Management Case

The overall LHP project has been and will continue to be managed to PRINCE2 project management standards with the LHP Project Team leading on delivery. The project governance and reporting structure for the CDH phase will be the same and is outlined in the management case, showing all key workstreams, task and finish groups, with boards and teams where approvals and decisions are made.

A project programme has been developed to control and track the progress and delivery of the project and resulting outcomes. The key milestones for the infrastructure programme are summarised below.

Milestone	Start	Completion
Confirm Scope and Develop OBC	14/07/2025	31/08/2025
Draft OBC Submitted to WG	05/09/2025	05/09/2025
HB OBC Approval	08/09/2025	15/10/2025
WG OBC Review and Approval	04/09/2025	16/10/2025
Planning Application	11/07/2025	15/10/2025
RIBA 4 and FBC Prep	28/07/2025	20/11/2025
HB FBC Approval and WG Submission	27/11/2025	27/11/2025
Scrutiny and WG FBC Approval	28/11/2025	23/01/2026
Contractor Mobilisation	23/01/2026	26/02/2026
Construction	01/03/2026	30/06/2027
Supplier Fit out of CDH	01/07/2027	31/08/2027
Commissioning	01/09/2027	31/10/2027

The milestones for the ISP procurement are shown in the following table, it is assumed that on appointment the provider will join the Infrastructure design team and work alongside the main contractor in the finalisation of the programme. It is possible this could lead to further programme efficiencies in the fitout and commissioning phases which will be clarified as the programme progresses.

Milestone	Start	Completion
ISP Tender Issue	18/08/2025	18/08/2025
ISP Tender Period	18/08/2025	19/09/2025
ISP Tender Evaluation	22/09/2025	03/10/2025
HB ISP Approval	06/10/2025	06/10/2025

WG ISP Procurement Approval	06/10/2025	16/10/2025
Intent to Award and Standstill Period	17/10/2025	31/10/2025
ISP Provider Appointment	31/10/2025	31/10/2025

Within the PRINCE2 governance, the PMO is classed as part of the Assurance function.

Programme

- Review of upcoming programme activity and milestones with LHP Technical PM and Project Director to determine outputs required by workstreams.
- Create lookahead programme highlighting key programme deliverables over coming weeks/months for dissemination to workstreams.
- Track workstream output and performance toward achieving programme deliverables and feed progress into monthly reporting – PMO drumbeat.

Risk

- Review of risk with LHP Technical PM and Project Director to review and update risk register based on workstream risks.
- Track workstream risks and feed into project reporting – PMO drumbeat.

Key Performance Indicators (KPIs)

- Work with LHP Project Director to determine workstream KPIs.
- Track workstream KPIs and feed into project reporting – PMO drumbeat.

Reporting

- Work with PMO governance lead to integrate programme, risk and KPI updates into monthly drumbeat reporting.
- Provide updates to LHP Design Team Meeting and Programme Board.

1.9 Summary recommendation and requirements

The works funded so far have delivered interim mobile capacity on the site alongside the site wide building demolition works. All other work has been focused on the design of the total Health Park to end of RIBA Stage 3 and commencement of RIBA Stage 4 Design Works for Phase 1 CDH and supporting side wide infrastructure.

The recommended option is to proceed to construct the CDH and carry out the site wide infrastructure. The construction to be led by MTX as main contractor and the buildings to be of modular construction. The service will be procured by an Independent Service Provider (ISP) who will deliver the imagining and endoscopy services as well as equip the unit.

Capital Spend to date is £18.1m. This represents total costs to date and includes the site purchase and site wide RIBA 1, 2 and 3 works.

The LHP Programme is seeking urgent approval of this business case and the release of funding of £2.771m for completion of the RIBA 4 and 5 design stage of the CDH to avoid delay to the programme. This funding forms part of the total funding ask within this OBC of £91.9m to deliver the total Phase 1 OBC works.

Strategic Case

2 Strategic context

2.1 Introduction

This section of the business case outlines the strategic context for the proposal to develop the regional Llantrisant Health Park (LHP) by explaining how the programme is strategically placed to support delivery of services across the three Health Boards in the South East Wales Region, Aneurin Bevan (ABUHB), Cardiff and Vale (C&VUHB) and Cwm Taf Morgannwg (CTMUHB).

The section will:

- Provide a summary of the Programme progress to date
- Provide an overview of the organisations working in partnership to successfully deliver the project.
- Outline how the project will contribute to achieving our business strategies and aims.
- Describe how the project aligns with other relevant local and national strategies.
- Describe the geographical context and local health needs.

2.2 LHP programme context and background

The LHP site was acquired in February 2023 by CTMUHB for £7.8m capital funding provided by Welsh Government. The site is located directly adjacent to the Royal Glamorgan hospital and extends over 20 acres. At the time of purchase the site included two storeys separate buildings totalling over 10,300sqm. The layout of the site already supported car parking for over 299 and separate front and rear access roads to the buildings.

As well as the existing buildings, there is a further developable area on the site for an additional building. The case for purchase described how the site was ideally suited to provide a high volume low complexity diagnostic and elective treatment centre with benefits for the whole South East Wales region. At the time of purchase the proposed scope of services to be provided at LHP were:

- A **Community Diagnostic Hub** comprising:
  - Diagnostic Imaging – CT, MRI and Ultrasound
  - Regional Endoscopy services
  - Plain Film X Ray
- A **Surgical Hub** comprising
  - Up to 6 orthopaedic theatres for high volume low complexity works
  - Up to 64 beds to support the orthopaedic theatres
  - A self-contained day surgery unit containing up to 6 theatres.

Immediately following the purchase of the site, a design team and internal programme team were appointed to commence site master-planning and design development. During this time, a successful early termination of the lease to the incumbent tenant was agreed giving CTMUHB full access to the site from October 2023. This access facilitated detailed and intrusive survey work to be undertaken which identified several limitations to the existing buildings impacting on their ability for use as healthcare premises.

At their request, a Strategic Overview Document was submitted to Welsh Government in September 2024 which gave a detailed overview of the programme and included a comprehensive option appraisal to identify the optimal way forward for the site infrastructure. The preferred option was the demolition of the existing buildings and replacement with modular buildings which delivers the quickest and most value for money solution. This can be found in Appendix 1.

This approach was formally considered by Welsh Government alongside the completed RIBA 2 design works at the Infrastructure Investment Board in November 2024.

Following this meeting, approval was given to proceed to RIBA 3 design stage and in January 2025 approval was given to demolish the buildings on the site in a separate advance works package. Demolition works commenced on 14 April and are due to complete by mid-September.

A condition of the approval to continue design work was that a business case was delivered at the completion of the RIBA Stage 3 of the development.

At this point, it was still assumed that the development would proceed under a single business case route but with phased completions with the CDH completing ahead of the surgical hub. , Alongside the capital design works there is an ongoing procurement exercise to identify a preferred partner to deliver the managed service contract for the CDH at LHP. This position changed in July with confirmation from WG that they would prefer to receive individual business cases for the separate phases of development. The revised delivery structure is as set below,

- Phase 1: CDH comprising MRI, CT, non-obstetric ultrasound, plain film x-ray capability and endoscopy including a regional endoscopy training centre of excellence. This business case also includes the wider site infrastructure required to facilitate later developments.
- Phase 2: surgical Hub comprising six orthopaedic theatres and supporting wards.
- Phase 3: six-day surgery theatres with supported space with full scope to be determined.

This outline business case has been prepared to seek outline approval for the **Phase 1 – CDH and wider infrastructure enabling works.**

The aims of the diagnostic regional solution outlined in this business case are:

- to enact a collaborative regional approach to recovery and delivery of sustainable radiology services
- to provide shared regional capacity for radiology
- to support the implementation of the new pathways that will enhance services
- to demonstrate optimal utilisation of our assets and resources across the region
- to address current waiting list backlogs and create sustainable capacity
- to reduce clinical risk on an equitable basis across the region
- to provide services that are accessible to the population of the region in line with the findings of Professor Sir Mike Richards' Independent Review of Diagnostic Services for NHS England[2].

Health Boards in South East Wales have committed to active collaboration where this delivers added value to clinical service delivery, access, and sustainability. Health Board planning teams (joined by clinical, operational, and other colleagues where beneficial) continue to meet on a regular basis to agree common approaches to strategic challenges, progress ongoing regional collaborative programmes, share experience / best practice and to consider future opportunities for closer working to mutual benefit.

Collaborative planning has involved each UHB leading a formal programme, with ABUHB overseeing ophthalmology and cancer, C&VUHB overseeing orthopaedics and stroke and CTMUHB overseeing diagnostics (consisting of endoscopy, pathology, and community diagnostic hubs).

[2] Diagnostics: Recovery and Renewal – Report of the Independent Review of Diagnostic Services for NHS England

2.3 Individual organisation overview

The LHP programme is being led by the LHP Project Team at CTMUHB in partnership with ABUHB and C&VUHB as part of the South East Wales regional network.

An overview of the main organisations who will collaborate to implement the changes and oversee services delivered from the new facilities is provided below.

2.3.1 Cwm Taf Morgannwg University Health Board

Established in 2009, CTMUHB (previously known as Cwm Taf UHB) provides primary, community, hospital and mental health services to the 450,000 people living in the County Boroughs of Bridgend, Merthyr Tydfil and Rhondda Cynon Taf. The UHB employs approximately 12,000 staff and has an annual budget of approximately £1.3 billion.

CTMUHB is located between the Wales capital, Cardiff, to the south, the coastal town of Porthcawl to the west, and the Brecon Beacons National Park to the north. Hospital sites include:

- Prince Charles Hospital
- Princess of Wales Hospital
- Royal Glamorgan Hospital
- Ysbyty Cwm Cynon
- Ysbyty Cwm Rhondda
- Ysbyty George Thomas
- Cefn Yr Afon
- Dewi Sant Health Park
- Glanrhyd Hospital
- Pontypridd Cottage Hospital
- Keir Hardy University Health Park
- Maestag Community Hospital
- Merthyr Renal Dialysis Unit
- Pinewood House

The proposed Llantrisant Health Park is situated close to the Royal Glamorgan Hospital.

2.3.2 Cardiff and Vale University Health Board

C&VUHB is one of the largest NHS organisations in Europe, employing approximately 17,000 staff and spend around £1.4 bn every year on providing health and wellbeing services to a population of around 472,400 people living in Cardiff and the Vale of Glamorgan. The UHB also serves a wider population across South and Mid Wales for a range of specialities.

The UHB is structured and designed into eight Clinical Boards, which cover the four main service areas. The eight Clinical Boards were created in June 2013 and have focussed on providing strong leadership in clinical areas, resulting in the acceleration of operational decision-making, greatly enhancing the outcomes for patients in their care. The Boards are held to account via the Executive Directors, and a process of scrutiny is ensured through monthly performance boards and a robust authorisation process. Hospital sites include

- University Hospital Wales
- University Hospital Llandough
- Noah's Ark Children's Hospital for Wales
- Barry Hospital
- St David's Hospital
- Hafan y Coed Mental Health Unit
- Cardiff Royal Infirmary
- University Dental Hospital

2.3.3 Aneurin Bevan University Health Board

ABUHB was established in October 2009 and serves the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and South Powys.

The UHB employs over 14,000 staff, two thirds of whom are involved in direct patient care and has an annual budget of approximately £1.7bn.There are more than 250 consultants in a total of over 1000 hospital and general practice doctors, 6,000 nurses, midwives, allied professionals and community workers. Hospital sites include acute sites:

- Grange University Hospital
- Royal Gwent Hospital
- Nevill Hall Hospital
- Ysbyty Ystrad Fawr

and a number of community hospitals and facilities, including:

- Rhymney Integrated Health and Social Care Centre
- County Hospital
- St Woolos Hospital
- Chepstow Community Hospital
- Monnow Vale Integrated Health and Social Care Centre

2.4 Regional overview

The Regional Portfolio is made up of three main programmes: Orthopaedics, Diagnostics and Ophthalmology. The three UHBs in South East Wales work together regionally adopting the following regional working principles:

- To reduce unwarranted variation and inequality in health outcomes, access to services and experience at a regional population level.
- To improve resilience.
- To make effective use of capacity and capability in whichever organisation it sits.
- To create critical mass for effective high quality care delivery when and where it makes sense to do so accepting that may not reside in every organisation.
- Take all opportunities to use the evidence base and best practice to improve quality, efficiency, productivity and use of finite resources.
- To enable clinical leaders, and others, to work together, lead together and learn together.
- Distributed leadership approach collaboration with benign intent, honesty, transparency and integrity in order to build trusting and effective relationships.
- To agree approaches to engagement and communications together.
- To avoid leaving anyone behind and learn from the past and progress in an open, honest and humble way.

The Regional Diagnostics Programme was initiated with the intended aim of developing and implementing both short and medium to long-term service changes which will provide more timely access to diagnostics in a sustainable way. The three health boards are committed to regional working, where clinically appropriate, through the Regional Portfolio Board.

The Regional Diagnostics Programme comprises three projects: radiology, endoscopy and pathology.

The Regional Endoscopy project was initiated with the aim of achieving the following:-

- A single regional service model philosophy across a range of sites, with appropriate differentiation of procedures undertaken at each facility where indicated – as determined by D&C data and providing capacity to support bowel screening activity if / as appropriate
- A single service team philosophy, with common roles, responsibilities, standard operating procedures, skill mix and staff rewards (banding etc.), together with a philosophy of learning and sharing of best practice at all levels of the service.
- Professional Joint Accreditation Group (JAG) accreditation across all facilities (actual or equivalent)
- Movement towards management of a shared waiting list and addressing the longest waiters on a regional basis
- Collaborative approach to training arrangements, working with HEIW via an academy model
- IM&T systems to enable the sharing of data, including e-referral, reporting and onward referral and appropriate interface with FIT testing results.
- Enhanced shared understanding of demand and capacity data, with common approaches and definitions.

The regional endoscopy planning has been informed by the following guidance and policy documents.

- Our programme for transforming and modernising planned care and reducing waiting lists in Wales, Welsh Government (2022)
- Diagnostics Recovery and Transformation Strategy for Wales (2022-2025)
- Independent Review of Diagnostics Services (Professor Sir Mike Richards) (2020)

Regional partners have worked together to develop overarching regional plans for endoscopy and imaging identify the demand and capacity plans and regional solutions to address. The following sections discuss the outcomes of this work.

2.5 NHS Wales business strategy and aims

This OBC illustrates how LHP will support a key priority to improve access to Diagnostic and Endoscopy services, and provides the infrastructure required for provision of these much-needed regional services.

The proposals are aligned with the national strategic context, supporting a broad range of national strategies and policies, including:

- The NHS Wales Planning Framework 2023-2026
- National Clinical Framework: A Learning Health and Care System (2021)
- The Parliamentary Review of Health and Social Care in Wales. Final Report. (January 2018)
- A Healthier Wales: Our Plan for Health and Social Care (June 2018)
- The Wellbeing of Future Generations (Wales) Act 2015
- Prudent Healthcare: Securing Health and Wellbeing for Future Generations
- Informed Health and Care: A Digital Health and Care Strategy for Wales (2015)
- NHS Wales Decarbonisation Strategic Delivery Plan 2021-2030.

The Diagnostics Recovery and Transformation Strategy for Wales 2022-2025 sets out the plan to improve, transform and redesign diagnostic pathways in Wales. Diagnostic services are a fundamental aspect of modern healthcare delivery. Clinical pathways cannot function properly without sufficient capacity to turnaround diagnostic tests, procedures and reports in a timely manner.

Large backlogs of diagnostic procedures hold the NHS back from making improvements in referral to treatment times, impair screening pathway effectiveness, result in poor patient experience, and have the potential to result in harms and poorer outcomes.

The Diagnostics Strategy outlines the need to:

Rapidly create additional diagnostic capacity	Move to a combined approach to diagnostics as a whole	Provide directional national NHS leadership, through the Diagnostics Board, as part of the NHS Executive	Expedite transformation in diagnostic service models

This national strategy seeks to deliver on the following aims:

- Improving outcomes and reducing pressure on secondary care
- Addressing unmet care need that has been exacerbated by COVID-19
- Enabling people to live longer, healthier lives at home
- Identifying treatments earlier in disease which enables intervention and care management more rapidly
- Creating a sustainable and intelligent integrated health system which reduces inequality
- Making Wales a great place to live and work.

The South East Wales Regional Diagnostics plan for Community Diagnostic Hubs aligns with this strategy and its aims through the intention to seek both a rapid expansion of diagnostic service access and the delivery of new models of care with a focus on providing centres of excellence which will attract and retain the required workforce.

Further support for new models of delivery was set out in Professor Sir Mike Richards' ***Independent Review of Diagnostics Services*** (October 2020); it highlighted the need for investment in equipment, facilities and workforce, and proposed a model of community diagnostic hubs established away from acute hospital sites.

The review sets out a vision for diagnostic hubs to provide a consistent approach to support health checks for people in deprived areas and potentially detect health issues that can be treated to prevent the conditions worsening. This model also aligns with national strategy through providing services away from acute sites, thereby improving access and reducing pressure on acute sites.

The Richards' report made a total of 24 recommendations, and the key elements are summarised in seven points here.

- **Diagnostic equipment and facilities should be expanded and upgraded as soon as possible.** High-quality data on imaging facilities already existed on which estimates of numbers of machines could be made. For other diagnostic modalities (e.g. endoscopy and physiological sciences) where national data are not available, baseline surveys should be undertaken.
- **The diagnostic workforce should be expanded substantially across all modalities**, with new roles being developed and training academies being established.

- **New service delivery models with new pathways to diagnosis should be established. These should separate emergency/acute and elective diagnostics, wherever possible**, to improve efficiency and reduce delays for patients. Community Diagnostic Hubs (CDH) should be rapidly established.
- **Improving connectivity and digitisation** should be prioritised across all aspects of diagnostics.
- **Innovative approaches to diagnostics should be evaluated** as quickly as possible and then implemented across the NHS. These are likely to include the use of artificial intelligence (AI) to assist human reporting in imaging, pathology and endoscopy. The use of new diagnostic technologies that can be used in patients' homes should be expanded, building on learning from home testing for COVID-19.
- Clinical and managerial leadership should be put in place for all diagnostic disciplines at national, regional and local/system/network levels.
- **Standardised data should be collected across all diagnostic modalities** to drive operational performance, support business planning and to inform service improvement.

The Richards' Report noted that **the key aims of Community Diagnostic Hubs are to:**

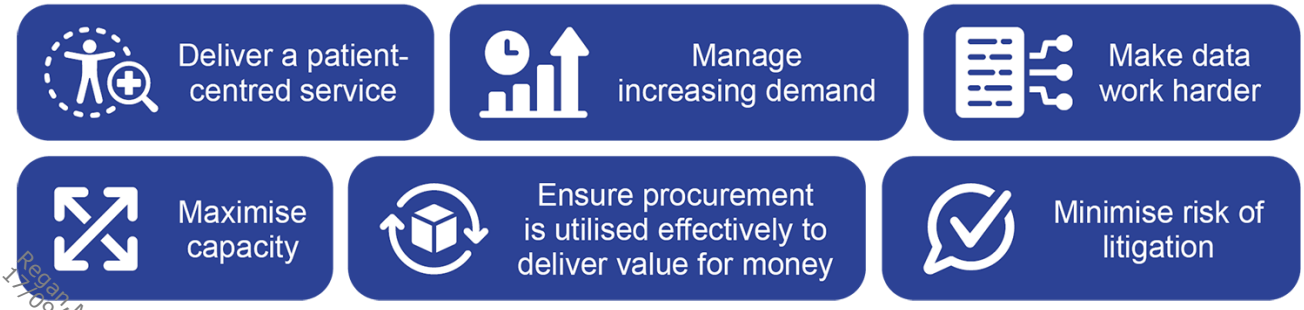
This model of Community Diagnostic Hub (CDH) provision has broad support from professional bodies such as the British Medical Association (BMA) Wales who advocated for increased access to diagnostics, in their letter to Welsh Government in May 2021.

It is also anticipated that CDHs will contribute to improve staff satisfaction, making every contact count, research and innovation and net zero carbon emissions. They should also act as anchor institutions for the populations they serve.

2.5.1 Getting it Right First Time (GiRFT)

The GiRFT Report considers the challenges of a post-COVID 19 Radiology service across the UK, with demand having increased between 2013 and 2019 by 22% with an expectation that this growth will continue.

The report captures a detailed account of the challenges faced by Radiology services and makes a number of recommendations to:



The report identifies a positive vision for change, of making radiology more patient-centric. That includes faster access to imaging, but also seeking to make services more convenient and accessible, and improving the physical environment of radiology departments.

This business case and the long term plans of the South East Wales region acknowledge and align with the points raised in the report and recommendations outlined.

The focus of the region's work is on both delivery of sustainable services through a range of means and seeking to better manage demand through alternative pathways.

2.5.2 Strategy for Developing a Regional Workforce Model for Wales

During 2021/22 Health Education and Improvement Wales (HEIW) supported the Imaging Workforce and Education Group (IWEG) and the National Imaging Programme to develop the *Building the NHS Wales Imaging Workforce Model – Strategy for Developing a Radiology Workforce for Wales*.

The Strategy sets out several recommendations to support and facilitate the development of a strong, resilient, and sustainable Radiology workforce for the future. These recommendations require both a national and local approach to implementation to ensure that the benefits are realised for both patients and staff. This includes developing plans for the recruitment of staff at a local level and identifying scope for workforce transformation opportunities.

3 Case For Change

3.1 Introduction

This section of the business case establishes the case for change for the development of the CDH by providing a clear understanding of:

- The spending objectives (what the proposals seek to achieve)
- Existing arrangements (what is currently happening)
- Business needs (what is required to close the gap between existing arrangements and what is required in the future).

3.2 Spending objectives for the LHP Programme

The main aim of the overarching LHP programme is to deliver high-volume low-complexity care away from crowded DGH sites; which will provide both additional capacity to meet ongoing increasing demand and free up existing resources to better meet emergency and unplanned care pressures. In turn, this should reduce patient wait times and facilitate earlier discharges on DGH sites across the region.

For Phase 1, the aim of this project is to deliver a Community Diagnostic Hub that is right-sized to meet the current and future needs of the local population, relieves pressures on existing DGH sites, supports the integration of primary, community and social care services, complies with regulatory standards and is suitable for the delivery of twenty first century healthcare.

The spending objectives listed in the table below were agreed by members at LHP Programme Board in September 2024 for the programme as applicable to all phases including phase 1 – CDH and Supporting Infrastructure.

Table 1 - Spending objectives

Ref	Theme	Spending objective	Benefit
SO1	Meet population needs	The delivery of an elective high volume low acuity model of care for the South East Wales Region on a phased basis. The first phase to focus on diagnostics and endoscopy. A second and third phase to focus on orthopaedics and day surgery respectively. Phase 1 services to be operational during the 2027/28 financial year. Future phases to consider further regional services such as pathology.	• Right-sized to meet current and future demand • Improves access to range of services • Centre of Excellence with efficient service delivery models and improved patient outcomes and increased throughput • Able to flex for the future
SO2	Maximise capacity	To maximise clinical capacity on the LHP site. To ensure that the maximum amount of available space is directed towards direct service delivery with supporting services managed from the neighbouring Royal Glamorgan site.	• Creates opportunities for centralisation of skillsets; centre of excellence • Enables greater collaboration regionally • Creates opportunity for one stop diagnostics, improved use of resources and appointments

Ref	Theme	Spending objective	Benefit
SO3	Innovation and standardisation	To facilitate and support the use of innovative design and delivery solutions in both clinical and non-clinical services. To implement standardised protocols and practices to promote efficient service delivery offering improved value for money and addressing the modifiable drivers of increased cost against English Tariff, excluding those aspects driven by Welsh Policy.	• Standardisation of consumables, with financial savings • Standardisation of best practice/policies; efficiencies, increased throughput, reduction of wait lists
SO4	Enable training / development of future workforce	To enable increased training and development of secondary care staff including accommodating more medical trainees and students.	• Accommodates placements for students (allowing role development and succession planning) • Improved workforce retention and recruitment
SO5	LHP Models of Care and Workforce Models	During phase 1 to ensure that the managed service provider delivers compliant and innovative models of care and workforce models, following the initial terms to develop innovative and new models of care to bring the CDH back into NHS management and control. . In Phases 2 and 3 to develop a new model of care and workforce models to support the delivery of the core services, the models will support efficient delivery of services	• Environment / ways of working that support staff welfare and wellbeing • Improved skills and job satisfaction • Improved patient outcomes • Multi-disciplinary working
SO6	Sustainable estate	To deliver a sustainable infrastructure on the site maximising decarbonisation and net zero opportunities.	• Complies with relevant standards; NZC, BREEAM excellent and energy performance • Opportunities for future additional service provision for South East Wales. • Opportunities for further regional reconfiguration and enabling of service and or estate rationalisation.

3.3 Existing arrangements

3.3.1 Radiology

Radiology is an important diagnostic test for a wide range of clinical conditions and is a key stage in many cancer and non-cancer pathways. Within Wales, the Welsh Government target for diagnostic tests (including radiology), is a maximum waiting time of eight weeks. Waiting times for radiology also form part of the 26-week referral to treatment time target (RTT) and 62 day single cancer pathway target, from suspicion to first definitive treatment. Many inpatients also require radiology as a diagnostic test, with waiting times, therefore, impacting patient outcomes and experience including length of stay and overall hospital efficiency.

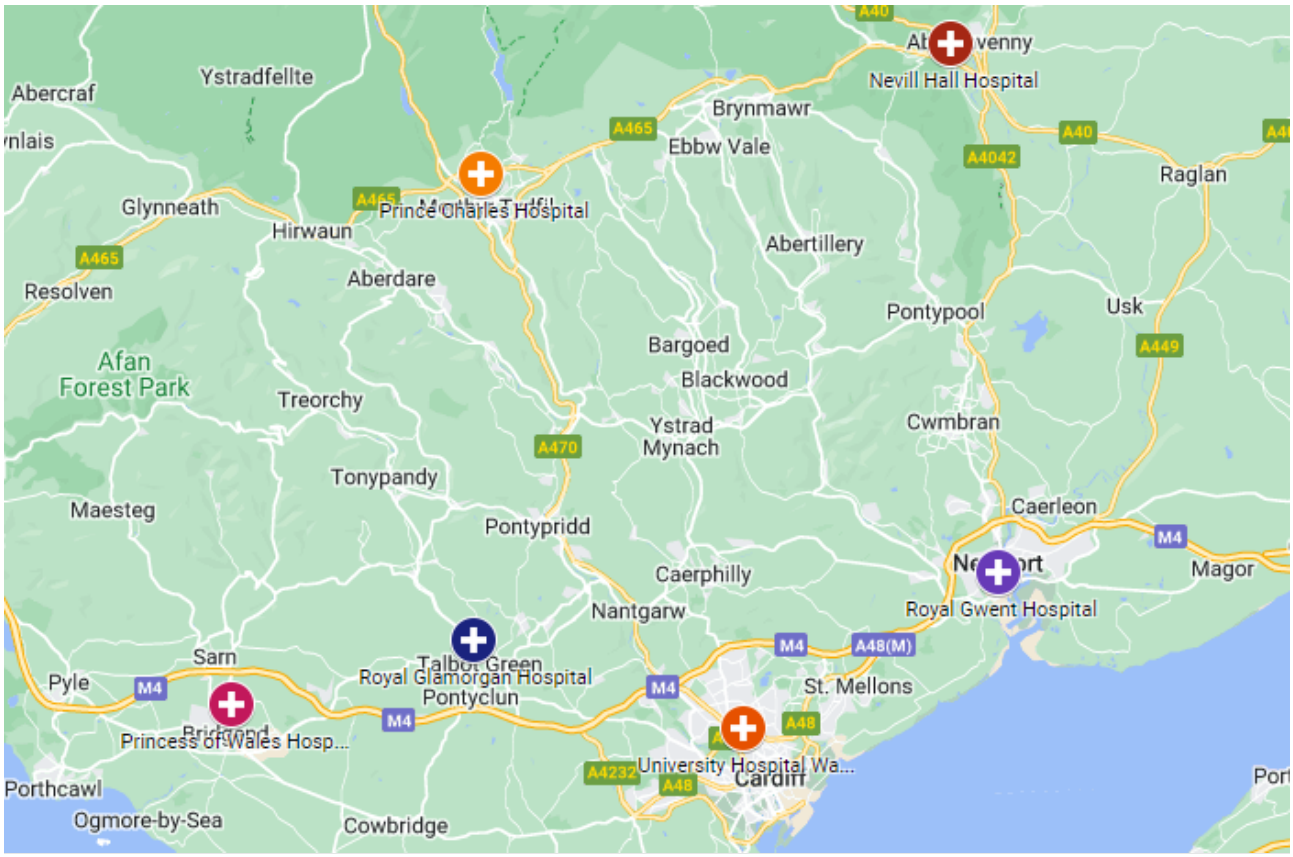
Current service provision for the region is delivered for each of the health boards' populations within each health board's geographic footprint. Patients from each health board currently access diagnostics in other health boards as part of agreed patient flows for specific service pathways but not commonly purely for diagnostics tests.

Additional capacity is delivered through a range of means including internal additional capacity using NHS clinicians (commonly referred to as waiting list initiatives) and in-sourcing.

Location of existing Imaging services

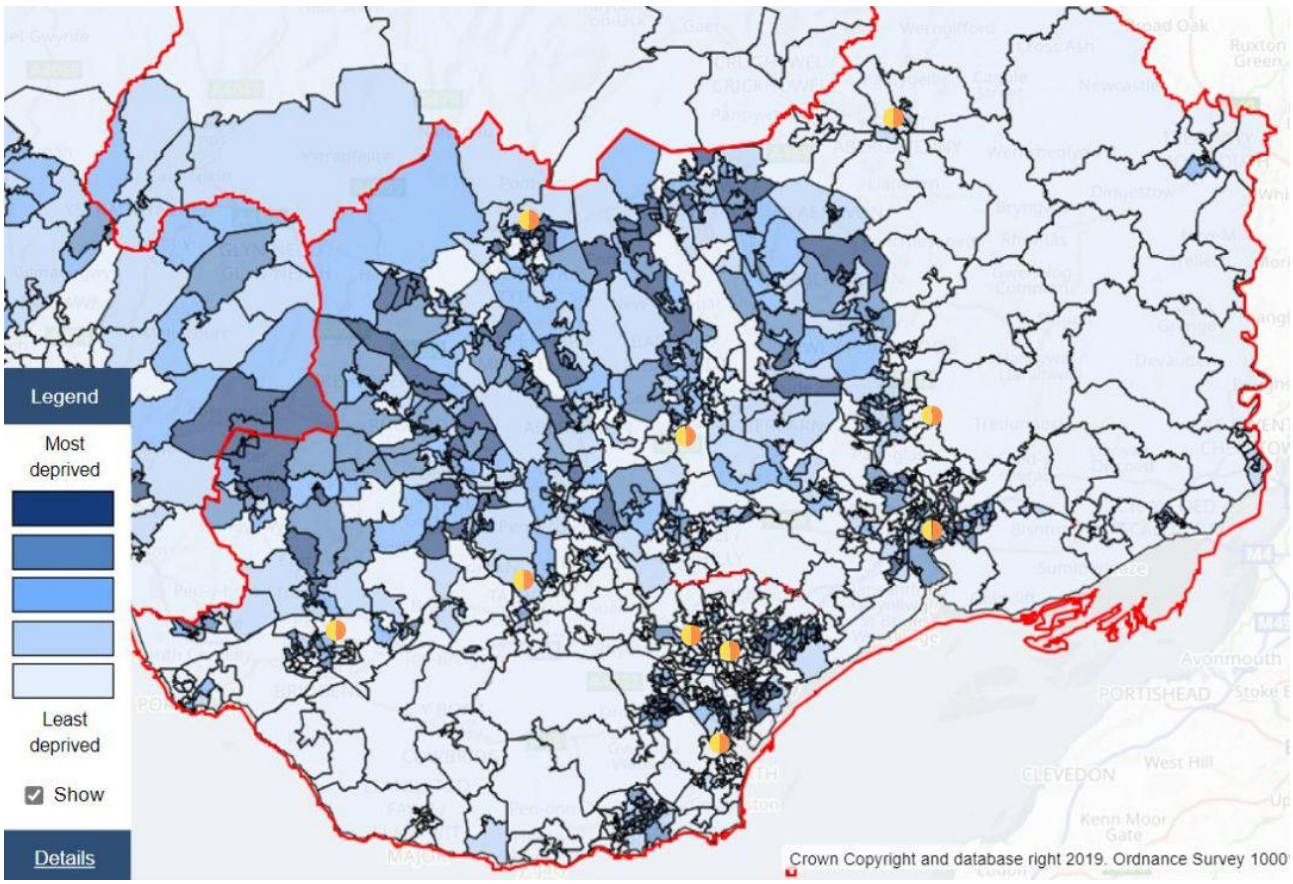
The South East Wales region comprises a large geographic area with varying ease of access for residents in discrete areas within the region due to road network and public transport options.

Figure 1 - District general hospital sites and the associated travel infrastructure



Given the agreed aim of ensuring access to residents living in areas of deprivation, the existing diagnostic infrastructure has been mapped against the Welsh Index of Multiple Deprivation (WIMD). The map below shows the location of CT and MRI facilities across the region.

Figure 2 - Location of CT and MRI facilities across the region (yellow and orange)



There is work underway being led by the regional imaging group to review service provision and create updated demand, and capacity modelling across the region. This will be used to develop a regional plan for imaging to address waiting times across the region. This is due to be completed shortly, however underpinning assumptions around demand and capacity have been used in completing this business case.

At this moment, only CTMUHB has confirmed an intention to commission imaging services from LHP. Cardiff and Vale and Aneurin Bevan University Health Boards have confirmed that they do not intend to commission services from LHP in the short term. Aneurin Bevan has indicated that it may consider doing so in the future, but there is no confirmed timeline for this. As this business case is focused on LHP only CTMUHB demand and capacity modelling will be included for the remainder of the case as they are the only confirmed contracting party.

The latest current imaging provision for CTMUHB is set out in the table below

Table 2 - Current delivery CTMUHB Imaging provision by site

Site	Modality	Days per week	Hours		Annual Capacity (Visits)
			From	To	
RGH	MRI 1	7	07.30	20.00	7,497
	MRI 2	5	07.30	20.00	5,187
	CT 1	7	08.00	20.00	16,752
	CT 2		09.00	17.00	7,350
	NOUS 4.5 rooms	5	09.00	17.00	14,994

Site	Modality	Days per week	Hours		Annual Capacity (Visits)
			From	To	
POW	MRI	5	07.30	20.30	5,434
	CT 1	7	08.00	20.00	16,752
	CT 2	7	09.00	17.00	7,350
	NOUS 4 rooms	5	09.00	17.00	13,314
PCH	MRI	7	07.00	19.30	1,476
	CT 1	7	08.00	20.00	16,752
	CT 2	5	09.00	17.00	7,350
	NOUS 4 rooms	5	09.00	17.00	13,314

In summary the total activity per modality based on patient visits is as set out below. These capacity figures have been derived by CTMUHB based on an average length of visit, days and hours of opening and includes accounting for planned downtime. The detail behind these calculations is included as appendix 2

Table 3 - CTMUHB summary Imaging capacity by modality

Modality	RGH	POWH	PCH	Total
MRI	12,684	5,434	7,476	**25,594**
CT	24,102	24,102	24,102	**72,306**
NOUS	14,994	13,314	13,314	**41,622**

3.3.2 Endoscopy

Endoscopy procedures are currently carried out from a range of sites across the three health boards. The table below sets out the permanent capacity arrangements in place across the region:

Table 4 - Endoscopy facilities, operating hours, days, sessions

Facility	No. rooms	Operating hours	Days / sessions	Procedures per year (ave.)
Aneurin Bevan UHB				
Grange University Hospital (weekends - inpatient / emergency on call only)	1	0800-1800	9 sessions gastro 1 session respiratory 5 days inpatients 7 days emergencies	1,956
Nevill Hall Hospital	2	0800-1800	5 days per week	5,392 (364 of which WG additional funds)
Royal Gwent Hospital	2	0800-1800	5 days per week	12,718 (902 WG)
	2		7 days per week	
Ysbyty Ystrad Fawr	2	0800-1800	5 days per week	5,845 (259 WG)

Facility	No. rooms	Operating hours	Days / sessions	Procedures per year (ave.)
Cwm Taf Morgannwg UHB				
Royal Glamorgan Hospital		0900-1700	5 days per week	7,435
Prince Charles Hospital		0900-1700	5 days per week	5,257
Princess of Wales Hospital		0830-1630	5 days per week	2,276
Cardiff and Vale UHB				
University Hospital Llandough (UHL)**	6	0900-1600	5 days per week 2 sessions	12,638
University Hospital Wales (UHW)	2	0900-1600	5 days per week 2 sessions	4,536

* *Although C&VUHB have eight rooms there is only a nursing capacity to run seven rooms and endoscopists to run six rooms. Currently 7 rooms are run with the support of an initiative with Medinet.*

** *Utilisation at UHL was relatively low during this period. Room 6 only became operational in Q4, and Room 5 faced ongoing staffing constraints which limited its use throughout the year.*

Detailed demand and capacity modelling has been undertaken by the National Endoscopy Programme for Wales (NEP), which has identified a recurrent shortfall in capacity. This demand is driven by increasing symptomatic demand coupled with the phased extension of the age range for Bowel Screening. This modelling concluded that there would be a six rooms shortfall in the South East Wales region by 2027/28 and has also recommended the establishment of regional endoscopy centres across Wales to support meeting a national shortfall in capacity against demand. This plan is included as Appendix 3 to this document and identifies an area outside of Cardiff for the facility in South East Wales. LHP would be an idea location for the same.

The regional diagnostic group have led on the development of the regional endoscopy plan based on work undertaken by NEP. The outcomes of this work are set out in the sections below but will focus on the whole region as both C&VUHB and ABUHB have included LHP additional capacity in their plans.

Whilst there are differences in the activity being undertaken across HB and sites, the group have confirmed that it is not possible to increase activity across all sites. This is due to workforce and estate constraints and there are recognised benefits to economies of scale of having larger consolidated units. This has supported the argument for the endoscopy service at LHP being regional provision.

3.4 Business need

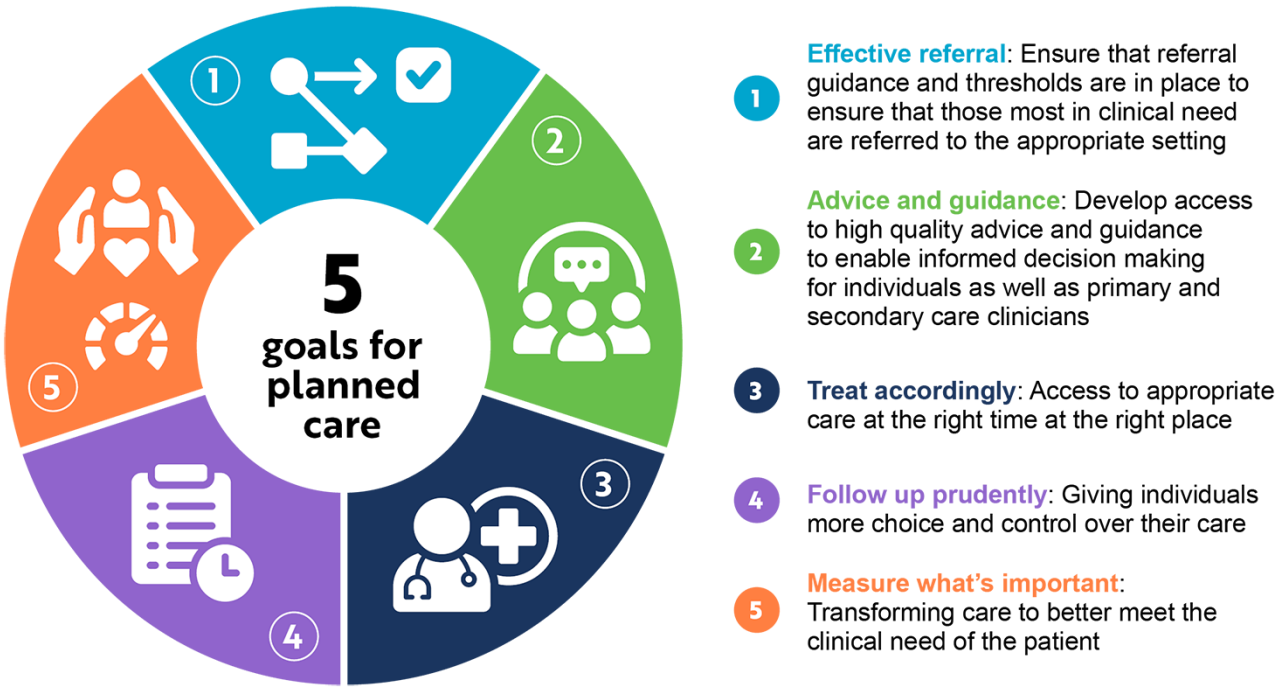
The vision is to create a standalone site for diagnostics that guarantees uninterrupted, effective and efficient services that address both current capacity shortfalls and offers opportunity to meet future demand growth. The vision is to provide patient centred care away from an acute hospital setting which also supports emergency care pathways by preserving capacity for unplanned and urgent procedures on DGH sites.

The need to significantly increase diagnostic and treatment capacity in Wales was set out in the Welsh Government Programme for Transforming and Modernising Planned Care and Reducing Waiting Lists in Wales which was published in April 2022.

The plan set a clear direction for Health Boards to recover the backlog of elective activity that has developed during the COVID-19 pandemic as well as responding to the increasing demand for diagnostic and surgical services due to demographic change and the challenge of health inequalities evident in many parts of Wales.

The plan has five main goals, which are underpinned by seven priorities to support and influence recovery planning and investment decisions as set out below.

Figure 3 - Welsh Government programme for transforming and modernising planned care goals and priorities



The seven priorities are:

1. **Transformation of outpatients**
2. **Prioritisation of diagnostic services**
3. **Focus on early diagnosis and treatment of suspected cancer patients**
4. **Implementing a fair and equitable approach to patient prioritisation to minimise health inequalities**
5. **Elimination of long waits at all stages of the pathway**
6. **Building sustainable planned care capacity across the care pathway**
7. **Provision of appropriate information and support to people**

The LHP programme aligns with planned care recovery programmes across with the region in the development of long-term additional capacity to support the delivery of efficient and effective solutions to support all three Health Boards to eliminate long waits and reduce overall waits within the patient pathway in terms of access to diagnostic services. This is in addition to each Health Board fully utilising existing assets as it is recognised that both are needed to ensure efficient diagnostic care for the region.

The ability to create bespoke capacity to maximise patient flow and increase efficiency and innovation in service delivery offers additional benefits to the region from investment in the programme. These include standardisation of patient pathways and clinical practices which should increase efficiency and improve patient outcomes, consolidation of services on LHP will release space on existing sites and act as a key enabler for future regional reconfiguration and transformation and the opportunity to standardise procurements thus achieving greater revenue savings on high volume items.

3.5 Increasing demand for services

All Health Boards in the region are operating waiting lists for endoscopy and for CTMUHB there are waiting lists for all imaging modalities. The following sections set out the CTMUHB demand and capacity for imaging and the regional demand and capacity for endoscopy services.

3.5.1 Radiology

The regional imaging group initially reviewed service provision, demand, and capacity to support the 2023 regional procurement to appoint an independent service provider (ISP), the procurement of which remains ongoing and will be discussed in later sections. This work is being updated following Judith Paget's letter, of 27 January 2025, which requested an integrated regional imaging plan to developed by the three Health Boards.

The refreshed demand and capacity information for the regional plan remains under development and will be presented to regional boards and WG under separate cover. The modelling for CTMUHB included in this OBC has taken the outputs from the work completed to date and ensured a consistent approach to data application and assumptions.

In the first instance an overview of current waiting times for patients within CTMUHB is as set out below and compared to the 2024 figures included in the submitted strategic overview document.

Table 4 - Current waiting times (CTM)

Date	Non Cardiac CT		Non-Cardiac MRI		Non Obstetric USS		Total	
	<8 weeks	>8 weeks	<8 weeks	>8 weeks	<8 weeks	>8 weeks	<8 weeks	>8 weeks
Jan-24	1,716	966	1,765	1,166	2,685	3,427	**6,166**	**5,559**
Jun-25	2,154	994	1,964	33	3,483	1771	**7,601**	**2,798**

Table 6 illustrates that there has been an overall increase in the number of patients waiting for scans across all disciplines with CT also seeing an increase in patients waiting over 8 weeks despite the presence of mobile imaging on the LHP site during 2024. Non recurrent additional capacity alongside some improvements in productivity have seen a fall in the over 8 week waits for MRI and ultrasound but these are now starting to increase again and are expected to continue to do so.

These waits can be explained when the latest demand and capacity data is considered. The location and operating hours of the current equipment with CTMUHB has already been detailed in Table 2 above, and has informed the capacity element of the demand and capacity modelling set out below (Table 6). Demand is based on information from CTMUHB with uplifts being based on outputs from modelling undertaken by Cardiff and Vale UHB and shared with the regional programme. The baseline 2025/26 Activity has been used as year one data as set out below:

Table 5 - Demand and capacity forecast / gap analysis

Modality	Actual capacity	Demand 25/26	Gap 25/26
MRI	25,594	25,675	-81
CT	72,306	82,657	-10,351
NOUS	41,622	43,351	-1,729

This clearly illustrates a shortfall in capacity in 2025/26 requiring non recurrent measures to be introduced and resourced at a premium cost to meet the level of demand based on an 8-week target. No improvements on this time can be offered and non-recurrent measures at a premium will be required to being performance in line with targets.

When demand growth is considered then the position clearly worsens with the table below setting out the position for the next 5 years. The demand increases are 8% for MRI, 8.9% for CT and 5% for ultrasound. This has been projected forward over a 5 year plan period with 2025/26 demand data contained in Table 5 above being used as the baseline year 0.

Table 6 - Imaging demand and capacity analysis

Modality	Current capacity	Forecast	2026/27	2027/28	2028/29	2029/30	2030/31
MRI	**25,594**	Demand	27,729	29,947	32,343	34,931	37,725
		Variance [3]	*-2,135*	*-4,353*	*-6,749*	*-9,337*	*-12,131*
CT	**72,306**	Demand	90,013	98,025	106,749	116,250	126,596
		Variance	*-17,707*	*-25,719*	*-34,443*	*-43,944*	*-54,490*
Ultrasound	**41,622**	Demand	45,519	47,794	50,184	52,693	55,328
		Variance	*-3,897*	*-6,172*	*-8,562*	*-11,071*	*-13,706*

There are several assumptions within the figures provided, namely that one CT on each DGH site is used as “hot capacity” and, whilst they are operated over 24 hours, the capacity outside the normal operating hours of 08.00 and 20.00 has been excluded, as this is demand-led and not operating at the same levels of efficiency.

There is a clear and significant gap in CT provision based on current capacity, which equates to in excess of one CT operating over 12 hours by 2026/27. Both MRI and NOUS are also showing year on year capacity shortfalls under the current model.

When considering the shortfall in actual capacity against demand, consideration has been given to whether utilisation of current assets has been maximised. There are some not insignificant issues with increasing capacity for imaging and there are existing pressures on workforce for both scanning and reporting. To deliver increased capacity it will be essential to secure workforce from the private sector to support the same. Despite this an exercise looking at the potential capacity increases that could be introduced has been developed.

[3] Surplus / shortfall

Table 7 - CTMUHB current v potential delivery capacity

Site	Modality	Current delivery model			Potential delivery model			Capacity increase
		Days/wk	Hours/day	Capacity [4]	Days/wk	Hours/day	Capacity	
RGH	MRI 1	7	12	7,497	7	12	7,497	0
	MRI 2	5	12	5,187	7	12	7,371	2,184
	CT 1	7	12	16,752	7	12	16,752	0
	CT 2	5	7.5	7,350	7	12	16,752	9,402
	NOUS 4.5 rooms	5	7.17	14,994	6	7.5	34,764	19,770
POW	MRI	5	12.5	5,434	7	12.5	7,722	2,288
	CT 1	7	12	16,752	7	12	16,752	0
	CT 2	5	7.5	7,350	7	12	16,752	9,402
	NOUS rooms	5	7.17	13,314	6	7.5	22,860	9,546
PCH	MRI	7	12	7,476	7	12	7,497	21
	CT 1	7	12	16,752	7	12	16,752	0
	CT 2	5	7.5	7,350	7	12	16,752	9,402
	NOUS rooms	5	7.17	13,314	6	7.5	22,860	9,546

Some of the key changes in capacity concern the move of the second MRI at RGH to a 7 day 12 hour working option with staffing required to be sourced to support the same. For CT all second machines on sites have been increased to seven- day and 12-hour working for elective patients. With NOUS the increased capacity modelling assumes that a further two rooms at RGH can be resourced and operated alongside the 4.5 rooms already in operation. In addition, it is assumed that 50% of the rooms on each site will operate a seven-day working model. For NOUS, hours of operation have not been increased due to the high level of manual intervention required in this modality

There are obviously a considerable number of risks around assuming the availability of this capacity, most notably around workforce availability and cost but also all consumable and supporting costs associated with this capacity increase. However, when the capacity increase is modelled against the demand levels mentioned above it can be seen that shortfalls in imaging capacity can be met in the immediate term.

Table 8 – Potential Demand v capacity based on Increased use of Existing Assets

Modality	Potential capacity	Forecast	2026/27	2027/28	2028/29	2029/30	2030/31
MRI	30,087	Demand	27,729	29,947	32,343	34,931	37,725
		Variance [5]	*2,358*	*140*	*-2,256*	*-4,844*	*-7,638*
CT	100,512	Demand	90,013	94,514	99,239	116,250	126,596
		Variance	*10,499*	*5,998*	*1,273*	*-15,736*	*-26,084*
Ultrasound	80,484	Demand	45,519	47,794	50,184	52,693	55,328
		Variance	*34,965*	*32,690*	*30,300*	*27,791*	*25,156*

[4] Number of annual visits
[5] Surplus / shortfall

By maximising capacity in the short term CTMUHB can continue to meet demand in all modalities until the end of 2027/28. From 28/29 shortfalls in MRI and CT start to become apparent. LHP is due to open in late summer 2027/28 so will be in place to meet the shortfalls within CTM.

On the face of it, CTMUHB has potential capacity to meet ultrasound demand over the next five years and beyond, however NOUS services are under extreme pressure on all sites within CTMUHB and are recognised as being a service under pressure nationally in Wales. Much is due to the high workforce input into this modality which leads to strains on the existing resource and sees higher levels of sickness and rest breaks generally required by sonographers.

The potential capacity relates to a desktop increase in operational hours and rooms reflecting the actual physical capacity, but for NOUS this is not realisable due to two important drivers:

- Firstly, changes to antenatal care pathways are driving an increase in obstetric scanning and this must be prioritised over elective scanning, due to the shorter timescales.
- Secondly, due to the volume of obstetric scanning and ergonomic challenges of our patient group, we are seeing increased sickness driven by RSI issues which is further limiting the actual capacity.

This makes the provision of a standalone service, provided by a workforce distinct to our obstetric services critical to deliver waiting times and provide ringfenced service whilst existing capacity can be focused on achieving obstetric scanning demand.

In addition, covering sudden and unplanned absences is almost impossible with a high level of very short term list cancellations taking place. Unlike CT and MRI where services can still run albeit at a possible lower throughput, a loss of staff in NOUS can lose a list for at least a day whilst cover is attempted to be found. In reality, this makes achieving the level of performance to meet the potential capacity numbers in ultrasound almost impossible.

To deliver these levels of capacity in house bestows a high level of financial and service risk on CTMUHB with no capacity to cover sickness. In addition, it is likely that any additional capacity realised will have to be diverted to support obstetric scanning. The delivery of services at a premium (agency or private sector rate) can be prohibitive and extremely difficult to secure regularly which explains why these levels of capacity have not been achieved.

The reality is that to meet growing demand levels, an increase in existing capacity on standalone ringfenced site will be required in NOUS to provide a sustainable future focussed service.

It should also be noted that the above tables consider growth in demand associated with population growth and changes, however additional demand associated with the straight to test cancer pathway has not been factored into this model, neither has the opportunity to create a shorter than eight-week pathway to imaging and diagnostic service. There are also expected to be increased pressures from programmes such as lung health screening which will put further as yet unmodelled pressure on imaging services.

Within CTMUHB there are a further number of emerging pressures that have not been factored into the demand figures above but will service to further increase pressures on imaging services over the next 12-24 months. These include:

- Plans to repatriate the Cauda Equina Pathway OOHs back from C&VUHB.
- There are plans in SBUHB to repatriate all CTMUHB activity in Cardiac MR and CT back to CTMUHB from Neath Port Talbot Hospital. The POW MRI will not cope with demand of MR Cardiac as only one session a month can be accommodated. An additional scanner will be needed to support this activity or activity transferred to LHP to enable additional session to take place at POWH.

- There are also plans for SBUHB to transfer all CTMUHB Maxillofacial services back and this will further increase demand on US and CT. Cone Beam CT will be a new service in PCH however the US demand will need to be met from somewhere.
- MCAT – physio service at NPT will be repatriated in near future resulting increased MSK requests for MR, US and X-Ray.

Radiology forms a critical part of the 26-week referral to treatment time target (RTT) and 62-day single cancer pathway target, from suspicion to first definitive treatment. As a result it is also anticipated that with increased capacity and significantly reduced waiting times increased radiology capacity will be required to deliver efficiencies across the health system by developing clinical pathways that incorporate diagnostics at an earlier stage, aiming to reduce pressures on services and improve the patient experience. A fundamental principle of this work is equity of access across the region, to ensure that these benefits are realised evenly to all patients and communities. Increased radiology capacity plays a key role in supporting accelerated pathways to treatment.

Additional permanent capacity can support Radiology services across South East Wales to consistently deliver within the required timeframes to provide a good patient experience, support inpatient flows, expedite cancer and referral to treatment pathways and increase compliance with component waiting times targets. To create permanent capacity will provide a better value for money solution than short term temporary investments.

3.5.2 Endoscopy

Despite significant work undertaken by the three health boards in the South East Wales region, the performance profile currently indicates a significant proportion of patients waiting more than the target waiting time of accessing diagnostic endoscopy within eight weeks.

In August 2024 there were nearly 8,000 patients waiting more than 8 weeks for a diagnostic endoscopy, although this position improved during 2024/25 because of additional non-recurrent funding.

Table 9 - Endoscopy position at August 2024

Health Board	Colonoscopy		Gastroscopy		Sigmoidoscopy		Total	
	<8 weeks	>8 weeks	<8 weeks	>8 weeks	<8 weeks	>8 weeks	<8 weeks	>8 weeks
AB	758	1,000	763	282	408	328	1,929	1,610
C&V	476	1,788	412	2,864	178	1,246	1,066	5,898
CTM	677	113	454	106	245	34	1,376	253
Total	**1,911**	**2,901**	**1,629**	**3,252**	**831**	**1,608**	**4,371**	**7,761**

The regular demand and capacity assessments facilitated for NHS Wales organisations by the National Endoscopy Programme (part of the NHS Wales Executive) have evidenced sustained growth in demand. This growth is evident for both symptomatic cases and for screening activity, due to the expansion of the Bowel Screening Wales programme to incorporate people aged between 51 and 55 years.

The impact of the growth in screening demand is set out by health board below and equates to a requirement for an extra 10 screening lists (one theatre) per week by 2027-2028.

Table 10 - Endscopy screening demand increase

Procedure type	Year -1 Oct 23-Sep 24	Year 0 Oct 24-Sep 25	Year 1 Oct 25-Sep 26	Year 2 Oct 26-Sep 27	Year 3 Oct 27-Sep 28
Cwm Taf Morgannwg UHB					
Index procedures	828	1,112	1,112	1,112	1,112
Repeat procedures	196	264	264	264	264
Surveillance procedures	78	67	72	132	178
Total Procedures	**1,102**	**1,443**	**1,448**	**1,508**	**1,554**
*Lists per week	7	9	9	9	10
Cardiff and Vale UHB					
Index procedures	819	1,100	1,100	1,100	1,100
Repeat procedures	194	261	261	261	261
Surveillance procedures	60	72	88	131	176
Total Procedures	**1,073**	**1,433**	**1,449**	**1,492**	**1,537**
*Lists per week	7	9	9	9	10
Aneurin Bevan UHB					
Index procedures	1,116	1,499	1,499	1,499	1,499
Repeat procedures	264	355	355	355	355
Surveillance procedures	89	115	136	179	240
Total Procedures	**1,470**	**1,969**	**1,990**	**2,033**	**2,094**
*Lists per week	9	12	12	13	13

The National Endoscopy Programme (NEP) has facilitated several national demand and capacity assessments, with the autumn 2023 assessment of data identifying a total capacity gap (symptomatic and screening demand) across the south east Wales region (based on existing capacity) of approximately six rooms by 2027/28.

The NEP modelling is based on theatres operating on 10 sessions per week at 10 points per list. Further details of the demand and capacity exercise are included in Annex 1. A summary of the total demand increase for the south east Wales region is shown in the table below (based on points).

Table 11 - SE Wales total Endoscopy demand

Procedure type	2024-25	2025-26	2026-27	2027-28
Symptomatic (inc surveillance)	82,911	86,662	90,616	94,783
Screening	16,498	19,906	20,313	21,084
Total	**99,409**	**106,568**	**110,929**	**115,867**

3.6 Proposed service provision at LHP

To support decision making around clinical capacity and delivery of operational services, the regional demand and capacity modelling for the key services, covered in the previous section, has been analysed to support the right sizing of LHP to ensure it can meet both current and future demand. This will be covered in turn for each of the services.

3.6.1 Radiology

There is a drive within Wales to improve our cancer performance, this will be heavily reliant on diagnostics, in particular Radiology. Current pathways often rely on patients being referred into secondary care where they are reviewed, with relevant imaging then being requested. To expedite the diagnosis, the ability to send patients straight to test is required, as identified in the optimal Single Cancer Pathways produced by NHS Wales.

The current scanners on our acute hospital sites are busy with the acute and unpredictable inpatient demand. This will always limit the ability to completely maximise service provision in line with potential capacity modelling and be able to offer prompt access to the complex imaging required by these patients. The CDH will revolutionise the way we diagnose patients. We can follow the relevant Single Cancer Pathways, allowing our Primary Care colleagues direct access to the necessary imaging. In addition, by utilising Health Pathways, non-cancer referrals can be fast tracked to the CDH.

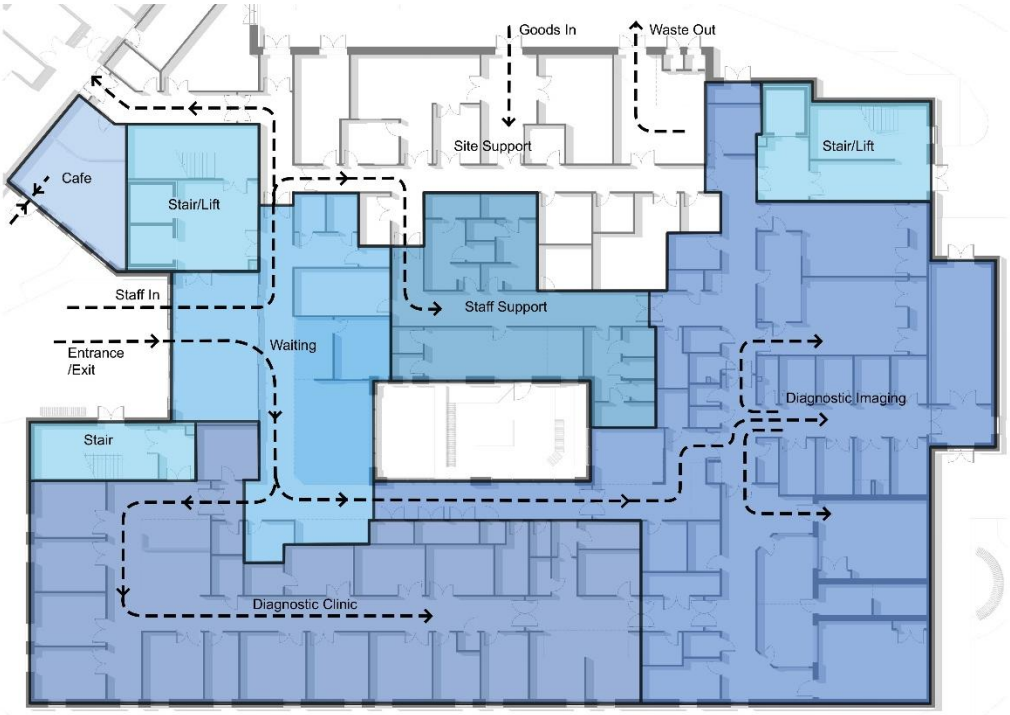
As a result of this, the direction for the infrastructure development has been to create the space to support the future growing demand and unknown increased screening and testing requirements. The proposed capacity will also be available to support regional partners should they determine that they cannot meet demand within their existing resources in the coming years.

The building has been designed to accommodate up to two MRI, two CT, three ultrasound and has the infrastructure in place to provide plain film x-ray. A suite of clinical and procedure rooms is included to support the provision of one stop clinics exploiting the adjacencies of the full range of diagnostic testing that will exist at LHP. These clinic spaces can focus on areas such as urology and lower GI which are two of CTMUHB's most challenged pathways for cancer performance. This gives the building a clear, cost effective and future focused approach to service delivery and ensures it can respond swiftly and effectively to changes or increases in commissioning arrangements, demand, screening requirements or be able to provide planned services away from emergency sites if required in the future.

This phased approach will enable rapid but stepped increases in diagnostic capacity, in line with the Diagnostics Recovery and Transformation Strategy alongside workforce planning and development to increase the NHS workforce, which will pave the way to potential future extension in operating hours of hospital-based diagnostic services, if required in future.

Currently, the proposed imaging provision at LHP will only be contracted by and provided for CTMUHB. The image below shows the current design for Diagnostics.

Figure 4 - Current Diagnostics layout plan



The CDH service provision is being procured from a third party provider, and the procurement remains ongoing at the time of writing this business case. The proposal is for an initial seven-year managed service contract with the provider supplying equipment and staffing to run and operate the imaging and endoscopy elements of the unit. The option appraisal to support this decision is set out in the economic case.

Recognising the need to step up services over time, the initial procurement documentation requests the provider to bid for the following contracted activity levels:

Table 12 - Diagnostic contracted activity

Year	MRI scans	CT scans	Non-obstetric U/S scan
Year 1 onwards	8,000	12,000	6,000

As this will be elective diagnostics and more HVLC work then it will be possible to undertake 8,000 scans on one MRI per year and the 12,000 CT scans would only require one CT. Therefore, it is expected that the initial contract with the provider would require one MR, one CT and two ultrasound rooms to be fitted out by them. The infrastructure offers an opportunity to step up capacity in a shortened timeframe should demand increase further or regional partners determine a need to commission radiology activity.

It is recognised that the discussion around the regional planning for imaging remains ongoing with the regional planning work due to complete shortly and present findings to their Boards. This will provide an overview of how all three organisations propose to meet their demand and capacity shortfalls within the WG confirmed position that capital funding will be directed towards LHP and not to other capital cases for the services within LHP.

The current pathway work with the service indicates that there are considerable benefits to the creation of a future proofed service by including two MRI and two CT alongside rooms for 3 NOUS in the design and infrastructure solution.

The business case proposes that the second MRI and CT rooms are included as shells within the building so that, as required, they can be equipped and utilised at a future date without disrupting flow and maximising design efficiencies. In addition, up to three ultrasound rooms will be included within the design alongside several procedure and clinical rooms. This will provide future flexibility to the CDH to expand and flex the services offered, including more multi-disciplinary one stop clinics utilising the existing imaging equipment alongside treatment spaces. This ensures the creation of a flexible, future focussed facility where one stop clinics utilising the on-site imaging technology can be delivered..

The proposed imaging design solution offers a regional solution if required in terms of the space and facilities built in. To attempt to create these spaces later will incur a premium cost, cause major disruption to the functioning unit and will compromise patient flow and efficiencies. To have a design which can incorporate demand growth and offer resilience and flexibility in its future usage is a unique opportunity within this programme. Capacity can also be managed to support Public Health screening requirements such as the lung screening programme or further other regional screening or diagnostic interventions. The capacity can also support major downtime across the region as required potentially reducing the need for expensive mobile hires for elective diagnostic procedures.

3.6.2 Endoscopy

The National Endoscopy programme (NEP) has facilitated several national demand and capacity assessments, using the Autumn 2023 data, identifying an expected gap across the South East Wales region of 6.3 rooms by 2027/28.

The following table summarises how the health board plans above impact on the original NEP capacity gap projection, together with the net recurrent requirement for a regional facility.

Table 13 - Endoscopy forecast capacity gap by 2027/28

	Rooms	Plan
NEP projected room gap 2027/8	6	
Net health board capacity requirements after individual plans		
ABUHB	0.5	Following 7/7 operating at Royal Gwent Hospital
C&VUHB	1.7	UHL operational model
CTMUHB	2	
Remaining gap to be addressed at regional facility	4.2	Four commissioned core rooms, supplemented by some academy activity and efficiency gains

The information supporting this has been shared in the section above and has also been presented to regional Boards to underpin the endoscopy model proposed for LHP. In addressing the shortfall in capacity, Health Boards have individual plans to mitigate the impact, and these plans are set out below as included in the overarching planning document produced in March 2025.

3.7 Regional Plans to bridge the gap between Capacity and Demand

The project undertook an option appraisal to identify options to meet the collective capacity gap. Key assumptions were that health boards would firstly work to fully utilise existing internal capacity, and then collaborate to address remaining capacity gaps, noting that workforce was a key constraint. On this basis, the appraisal identified a preferred option of the development of a regional endoscopy centre with a co-located regional training academy. The regional training academy is described further in section 3.7.4.

The subsequent site option appraisal identified Llantrisant Health Park (LHP) as the only suitable site within the south-east Wales region for a development of this nature and size.

Individual UHB plans (covering the interim period prior to the opening of a regional facility) are set out below. It should be noted that these plans will be pivotal in managing endoscopy demand in the South East Wales region alongside the infrastructure at LHP. The revenue funding to support these measures will need to be determined alongside the revenue requirements to fund LHP.

3.7.1 Aneurin Bevan University Health Board

ABUHB has reviewed its projected demand and capacity position, based on NEP assumptions of 5% core demand growth per annum and the published future commissioning intentions of Bowel Screening Wales. It is intended to move to full utilisation of the Royal Gwent Hospital endoscopy facility from April 2026, with all four theatres extended to seven days working from that date. Based on a 49-week per year operation (inclusive of backfill), this would deliver an additional 392 lists and enable the health board to maintain all relevant diagnostic targets until 2027/28, this will require additional revenue to deliver.

If the additional activity is delivered from April 2026, the resulting capacity gap in 2027-2028 is minimal, equating to approximately one list per week. From 2028-2029 the recurrent gap amounts to approximately five half-day sessions per week, or half a theatre. It is intended that this activity would be delivered through LHP (made up of screening and surveillance procedures), thereby enabling continued maintenance of all relevant diagnostic targets.

3.7.2 Cardiff and Vale University Health Board

C&VUHB has extended its capacity in University Hospital Llandough with two new theatres in 2024. The plan for the health board incorporates maximising the use of these theatres, noting workforce constraints have been a limiting factor.

The health board has undertaken a demand and capacity assessment and has identified a minimum requirement for 17 sessions or 1.7 theatres to be sourced from LHP from 2027/28. This activity will be a mix of both screening and surveillance procedures covering colonoscopy, flexi - sigmoidoscopy and gastroscopy (surveillance only).

3.7.3 Cwm Taf Morgannwg University Health Board

CTMUHB extended its internal capacity in 2024 with the opening of an additional endoscopy theatre at Prince Charles Hospital. During 2025, the Health Board experienced reduced capacity from the impact of the critical incident at Princess of Wales Hospital, however at the time of writing, works have been completed, and capacity has returned to previous levels. During the remainder of 2025-26 the Health Board will work towards the implementation of phase two of the internal endoscopy plan, which incorporates:

- Expansion to the substantive staffing of the third unit at Prince Charles Hospital

- Development of the trans-nasal endoscopy service. This will review the requirements for gastroscopy
- Implementation of manometry services.

Notwithstanding these developments, the Health Board will have a residual capacity gap equivalent to two theatres of activity from 2027/28 onwards.

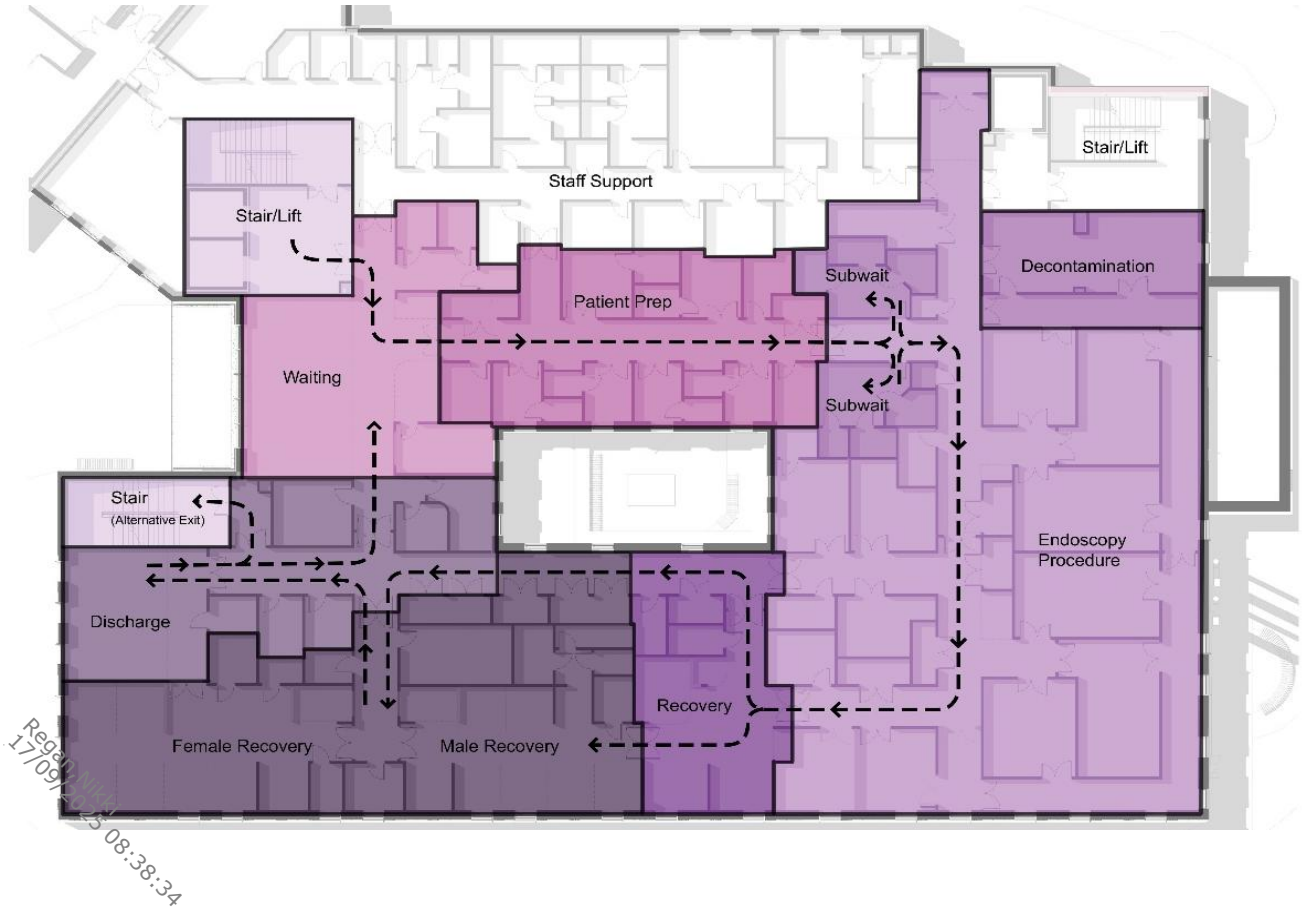
The anticipated requirement for CTMUHB remains as per the case mix established for the regional service specification in 2024 (40% gastroscopy, 40% sigmoidoscopy and 20% colonoscopy).

As part of the regional endoscopy planning, and as detailed above, it was identified that, should all local plans to optimise existing infrastructure be realised, there will be a need for just over four rooms to be commissioned in 2027/28.

The regional modelling confirms a need for four operational endoscopy rooms by 2027/28 based on the most recent demand modelling and regional Health Board agreed plans. In addition, there is a desire to create at least one training room, which would equate to a requirement of just over five rooms at LHP. The current design incorporates six endoscopy rooms and associated supporting space. This provides a sustainable and resilient approach to the development and enables the absorption of future growth or changes in screening requirements by Public Health Wales, as well as offering training opportunities and resilience in case of down time in any room.

The image below shows the current proposed layout for the Endoscopy unit, these designs have been discussed with the Welsh JAG lead, who has confirmed that they conform to current JAG requirements. It should also be noted that the physical aspects of CTM's endoscopy Unit at Royal Glamorgan Hospital make it practically impossible to achieve JAG compliance and therefore the LHP facility will increase the levels of endoscopy undertaken in a compliant estate.

Figure 5 - Proposed Endoscopy layout plan



3.7.4 Regional Endoscopy Training Academy

Endoscopy is a complex and evolving specialty requiring specialist education and training for all staff. Tailored training improves recruitment, retention, competency, and patient care. The JAG Endoscopy Training System (JETS) provides a structured framework for workforce training, progressing staff from foundation to leadership levels, with mandatory training requirements for JAG accreditation.

Endoscopy Training Academies have been established in the UK to enhance multi-professional learning, innovation, and workforce development. They have the potential to provide greater health system value than traditional education models as they:

- Enable training and supervision capacity to be expanded quickly and much more cost effectively
- Enable innovation in training through rapid at-scale adoption of technology enhanced learning and new multi-disciplinary learning models
- Accelerate independent working and service delivery productivity of trainees
- Enable more geographical equity in the distribution of training and hence the health professional workforce.

Through the Endoscopy Training Academy, training is provided to the whole endoscopy workforce, including nurses and support staff, in a multi-disciplinary environment. A south-east Wales Endoscopy Training Academy, co-located with the regional endoscopy suite, is proposed to support sustainable workforce training.

The development of a regional endoscopy training academy is a priority for Health Education and Improvement Wales (HEIW), as set out in its 2024-2027 intermediate medium-term plan. HEIW has developed a formal proposal for the training element of the academy, but this does not include consideration of the required physical infrastructure. The current working assumption for the LHP programme therefore includes the provision of a minimum of one theatre for the development of the academy. HEIW have committed to regular meetings with the regional endoscopy planning team to develop plans in alignment and will provide confirmation of the recurrent cost model for the academy for inclusion in the LHP full business case which will be prepared for health boards' consideration by November 2025 at the latest.

The requirements from health boards to facilitate a regional academy are to be confirmed. C&VUHB recently undertook a fixed term funded trial of an accelerated training programme, and the learning from this is informing the planning for the academy.

Following meetings with the design team and workstream meetings, the Endoscopy element of the Skills Academy includes; two theatres dedicated to providing training lists both for morning and afternoon sessions five days per week (Mon-Fri). The top floor is planned to be utilised as a multi-professional training space for simulation training (use of ex-vivo models) and a lecture theatre or seminar room for training courses (including live AV links to theatres thus meeting requirements and supporting endoscopy and surgical training.

One of the aims of the academy is the ability to train adequate endoscopy staff to allow the region to fill vacancies to provide safe and high-quality care and reduce reliance on outsourcing and in sourcing. This will also support the transition of the managed service contract staffing back to NHS staffing in LHP by the end of the contract. The current plans will support an environment appropriate to the delivery of all the course types required to develop the endoscopy workforce within the national requirements and standards for training set out by the JAG, as well as ensuring practice considerations.

In terms of the allocation of staff in the two theatres, the proposal is that:

- The Endoscopy Academy would provide 'the Trainer' (this will be a Centrally Contracted Endoscopist whose sessional time is paid for by HEIW), in addition HEIW will also fund and co-ordinate the process by which trainees are allocated to attend training lists and ensure backfill arrangements are in place in the event a Trainer is suddenly unavailable. The Trainers (endoscopists) will be responsible for following up any histology and ensuring that additional tests e.g. imaging is reported.
- The LHP 'host UHB' will be responsible for providing the Nursing Staff to staff the two theatres and will provide all the available endoscopic equipment, accessories and IT systems required to perform a high-quality endoscopy and report the findings onto an integrated reporting systems (so that results are available on WCP). The theatres will be equipped with both Scope Guides and AV (SMOTS) systems to ensure an appropriate training environment.
- For the third-floor training space HEIW will provide any endoscopic equipment that is solely required for model training and will provide the administrative and technical staff to support all endoscopy courses. These staff will require appropriate accommodation in the training space, but it is understood that they will need to share the accommodation / facilities with staff supporting other speciality courses and training.

An Endoscopy training facility within the academy has the potential to provide (aside from basic endoscopy training) immersion training, train-the-trainer courses, colonoscopy upskilling, non-technical skills, national assistant practitioner training, simulation and upper GI best practice training. Additional training opportunities within a skills academy include:

- Perioperative workforce; accelerated anaesthetic practitioner programmes, assistant peri-operative practitioner programmes, foundations of perioperative practice and surgical first assistants.
- Additional activities; OSCE preparation, pre-induction support for health and social care staff, national bronchoscopy and EBUS training, clinical skills for pharmacists, biomedical scientist registration portfolio, cultural humility resources, high volume cataract surgery resources and research institute which is attractive to current and potentially new staff.

3.7.5 Accelerated training for Endoscopy

Through investing in accelerated training infrastructure, the Endoscopy Academy will be able to plan, implement and target accelerated training to enable the trainee workforce to be available earlier to support service delivery. As JAG Certification is the UK standard for independent practice as an Endoscopist, if this has been achieved before completion of Specialist Training, the Endoscopist can actively contribute to service delivery. This affords Health Boards the option to address rising demand and capacity challenges by utilizing this workforce resource early in the training cycle through allocation to suitable lists and procedures.

The recommended approach would deliver 70 hours of intensive, hands-on training over a two-week period under 1:1 trainer supervision. This method compresses the traditional learning curve by up to 45%, enabling trainees to reach competency faster.

Modelling has demonstrated significant gains from accelerated training in terms of an increased number of certified upper GI endoscopists (within one year) and colonoscopists (over two years). A similar approach can be adopted for nurses, where acceleration can reduce the time taken to achieve independent practice for new nurse endoscopists from 9-12 to 5-6 months.

A pilot of accelerated endoscopy training commenced in University Hospital Llandough (CV) in January 2025 for a period of three months and anticipates within this short period in delivering endoscopies, bringing endoscopists through to achieve JAG upper GI Endoscopy Certification.

Projected additional endoscopy procedures delivered per year post accreditation, based on modelling

- Registrars: 256 OGD procedures or 128 colonoscopies (based on 1 list/week for 32 weeks per year adjusted for on calls and leave).
- Clinical Endoscopists: 1,408 OGD procedures or 704 colonoscopies (4 lists/week for 44 weeks per year).

Estimated workforce output

- Year 1: 7–11 JAG Certified UGI endoscopists.
- Year 2: 10–22 JAG Certified colonoscopists.

If 50% of these certified trainees were allocated regular service delivery lists, it would result in:

- **2,000 additional** UGI endoscopies annually.
- **1,280 additional** colonoscopies annually.

4 Benefits and Risks

This section of the business case identifies the benefits, risks, constraints and dependencies in that have been considered when developing and assessing the options for the development of Llantrisant Health Park.

4.1 Benefits case

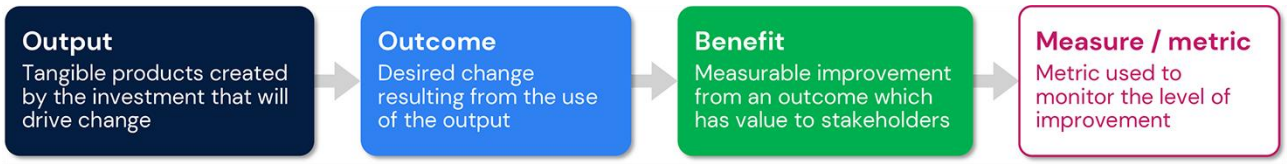
A systematic approach was undertaken to develop the benefits analysis as outlined in the diagram below.

Figure 6 - Benefit analysis process

A significant amount of work has been undertaken during the development of the programme to identify the benefits of LHP.

This was consolidated within a series of workshops during April 2025 using the investment logic mapping approach outlined in the diagram below, following the restructure of the programme the benefits were reviewed to only include those directly related to Phase 1 :

Figure 7 - Investment logic mapping approach

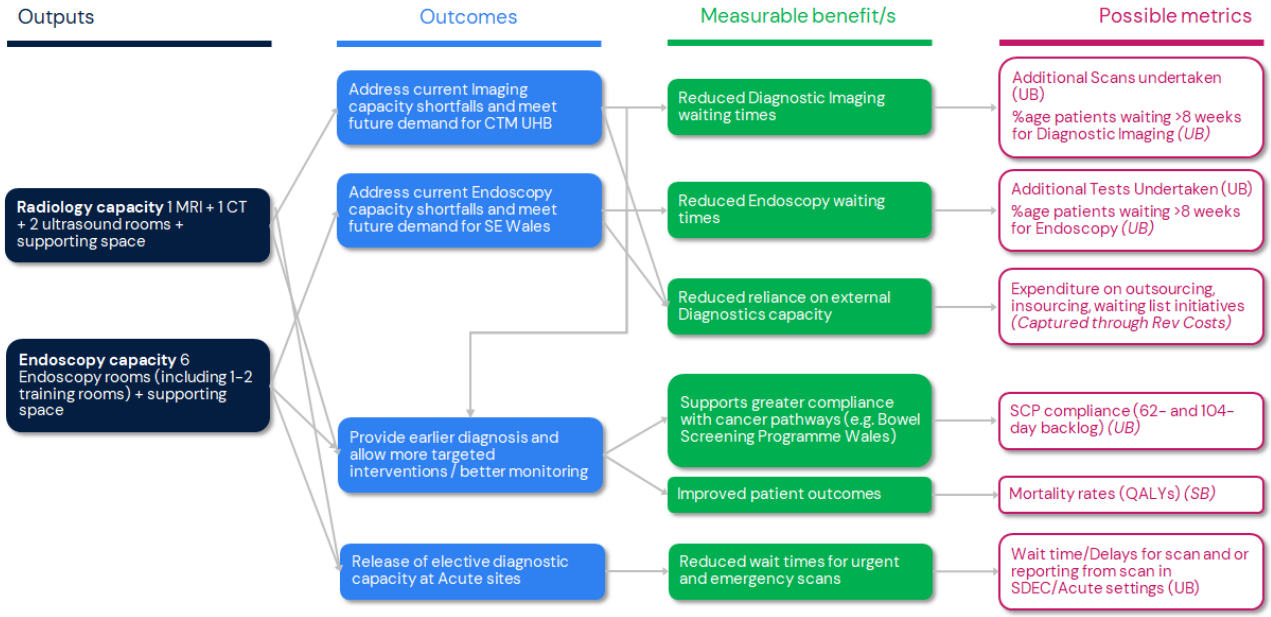


4.1.1 Creation of Diagnostics Centre

Delivery of the CDC will allow LHP to provide additional Diagnostic Imaging and Endoscopy capacity in the region to address current capacity shortfalls and ensure future demand can be met. As well as reducing waiting times for patients, this will support the cancer pathway by enabling earlier diagnosis, more targeted interventions and improved monitoring.

This will lead directly to delivering better patient outcomes, specifically improved cancer survival rates. In addition, the additional capacity will reduce reliance on expensive external Diagnostics capacity such as outsourcing, insourcing and waiting list initiatives.

*Figure 8 - Benefits mapping: creation of **Diagnostics Centre***

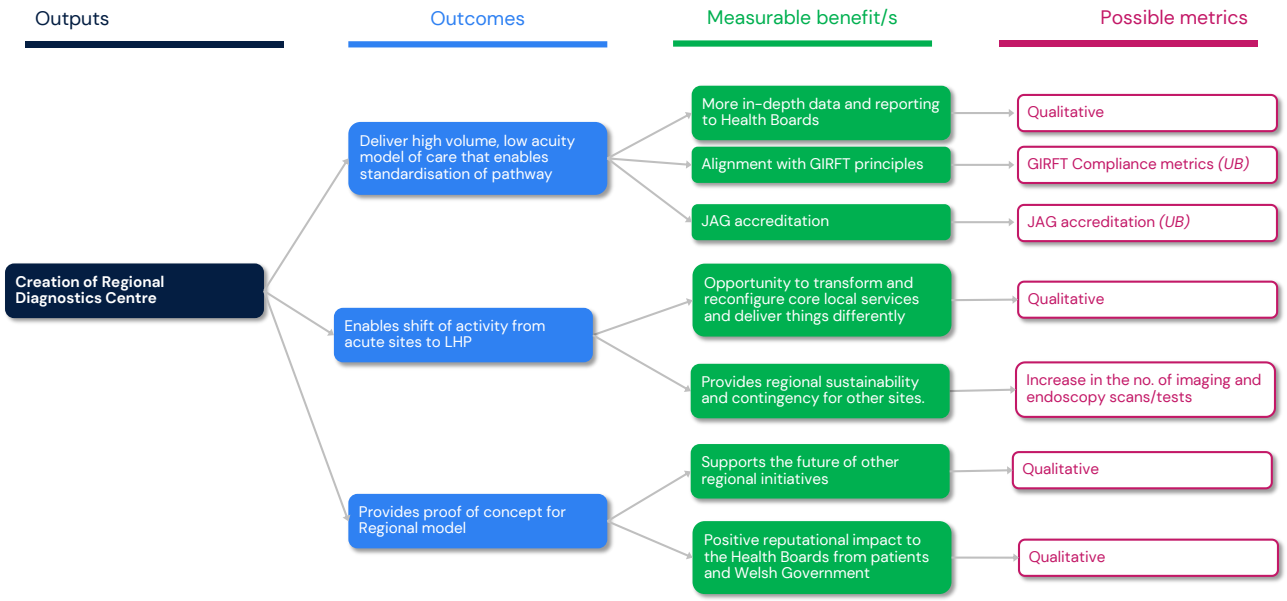


4.1.2 Model of care transformation

LHP will enable delivery of high volume, low acuity model of care that will enable the standardisation of patient pathways. This will result in better value for money due to increased throughput and better use of resources, reducing the average cost per test and providing opportunities for more efficient procurement. It will ensure services align with GIRFT principles and achieve JAG accreditation.

By providing capacity to shift activity from acute sites, the new CDC provides an opportunity to transform and reconfigure core local services and deliver things differently. For instance, the transfer of activity from CTMUHB to LHP provides opportunities to release space across the Estate in the future for other developments or to address risks around deteriorating facilities and reduce backlog maintenance. It is anticipated that these benefits may not accrue to regional partners for whom LHP will represent additional capacity only. The successful delivery of a regional centre will also provide proof of concept as the basis for the development of any future regional pathways.

Figure 9 - Benefits mapping: ***model of care transformation***



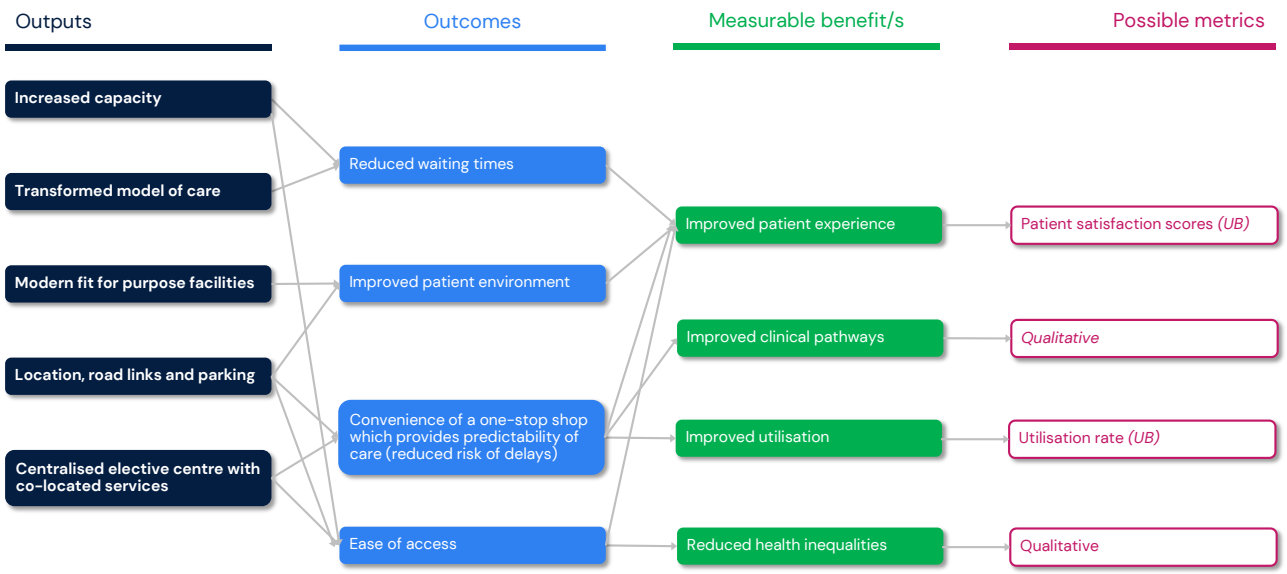
4.1.3 Improving patient experience

The outcomes presented above, such as reductions in waiting times, will contribute to a significant improvement in patient experience.

This is enhanced by the modern fit for purpose facilities and the ease of access the location of LHP offers, with its good road links and parking. Having a centralised elective centre with co-located services provides the convenience of a 'one-stop' shop clinic with greater predictability of care.

This contributes to more confidence in booking patients and tests which should lead to improved utilisation. In general, the improved access and reduced waiting times ensures a more equitable service is available within the region.

Figure 10 - Benefits mapping: ***patient experience***

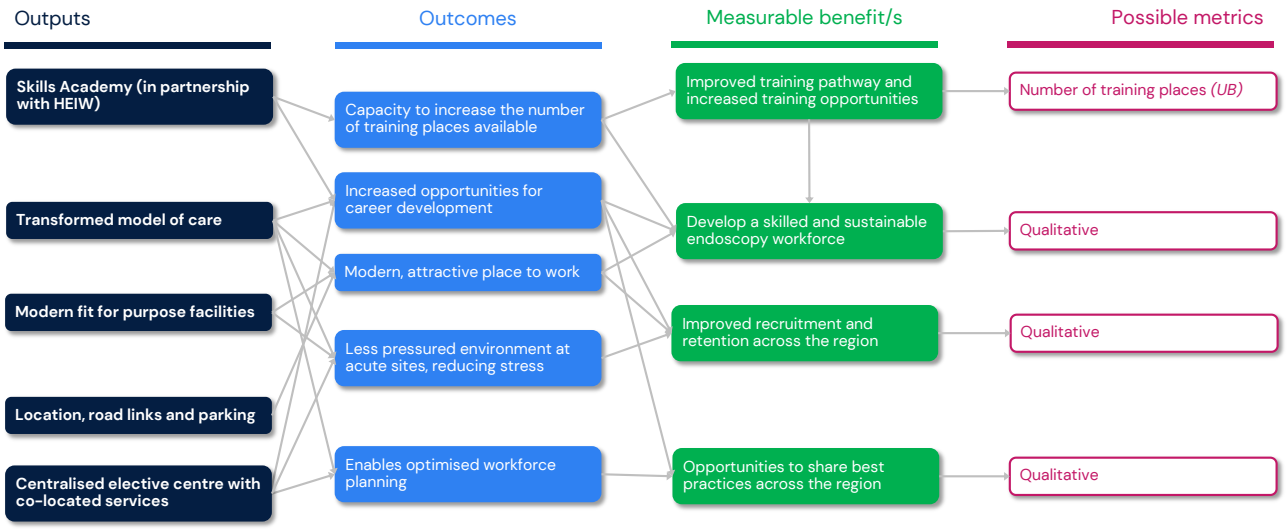


4.1.4 Delivering a sustainable workforce

Delivery of the Endoscopy Academy in partnership with HEIW will provide significant opportunities to increase the number of training places available in the region.

The improved training pathway and increased training opportunities, along with the modern fit for purpose facilities and a consolidated service model that enables can reduce pressures on acute sites contributes to staff satisfaction across the region. It also creates an attractive place to work in the future which will support recruitment and retention of highly trained health professionals.

Figure 11 - Benefits mapping: ***sustainable workforce***



For the CDH, the initial plan is that the workforce will largely be provided via the managed service contract with the appointed provider. Therefore, there will be direct benefits for them in terms of recruitment and retention however these benefits are expected to flow to regional partners when the service is brought back in house at the end of the contract. It is clear therefore, that the majority of the workforce benefits will be indirect for the contractual phase.

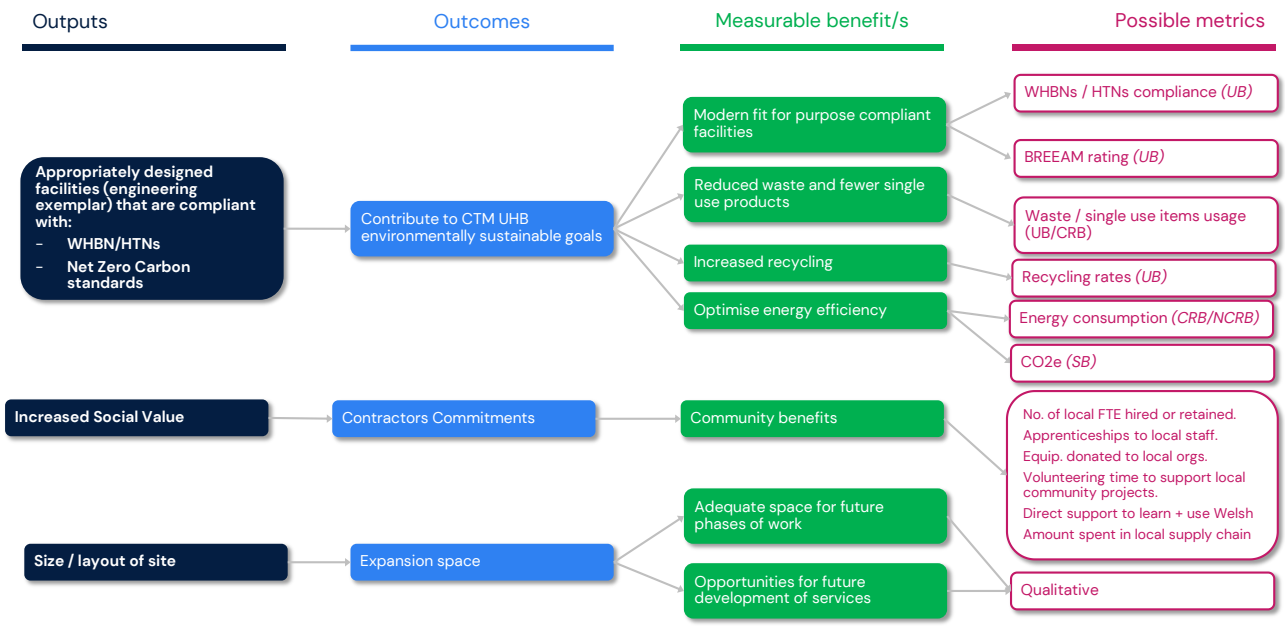
4.1.5 Providing a sustainable estate

The delivery of appropriately designed compliant facilities provides opportunities to contribute to CTMUHB's environmentally sustainable goals and national strategies around decarbonisation, by ensuring they are compliant with WHBNs and HTNs, achieve BREEAM rating of Excellent and optimise energy efficiency.

The transformed model of care with its standardised pathway is likely to make it easier to implement and maintain sustainability programmes that CTMUHB has instituted in other areas, such as reducing waste and single use products.

The site also provides a level of future proofing by providing expansion space that offers opportunities for other future developments.

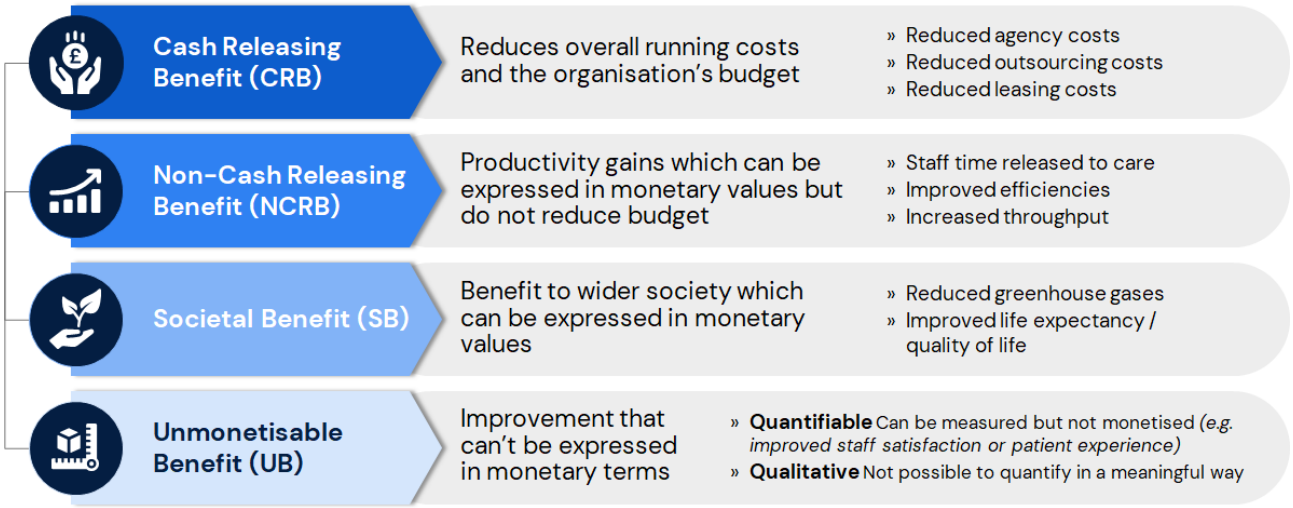
Figure 12 - Benefits mapping: ***sustainable estate***



4.2 Main benefits

The investment logic, outlined above, resulted in the identification of the main benefits for each of the categories outlined in the figure below.

Figure 13 - Benefits categories



The main benefits are summarised in the table below.

Table 14 - Main benefits

Theme	Benefit	Beneficiary	Type	Possible Metrics
Creation of diagnostics centre	Increased Imaging and Endoscopy Capacity	Patients / Health Boards	Quantifiable	Additional scans / test undertaken
	Reduced waiting times across Endoscopy and Imaging	Patients	Quantifiable	Number of patients waiting over 8 weeks
	Release of elective diagnostic capacity at Acute sites, which can be used for urgent and emergency care patients/pathways.	Patients	Quantifiable	No. of scans undertaken in SDEC Wait time / delays for scan and or reporting from scan in SDEC/Acute settings
	Supports greater compliance with cancer pathways leading to better patient outcomes	Patients	Societal	SCP compliance (62- and 104-day backlogs) Improved mortality rates (QALYs)
	Improved patient outcomes (non-cancer related):	Patients	Societal	No of Additional Endoscopy tests undertaken (leading to improved mortality rates (QALYs))
	Reduced reliance on external Diagnostics capacity	Health Boards	Captured via revenue costs	Expenditure on outsourcing, insourcing, waiting list initiatives
	Assist with meeting 'Straight to Test' guidance.	Health Boards	Quantifiable	No. of direct referrals from GPs to Radiology
Model of Care Transformation	Greater alignment with GIRFT principles and achievement of JAG compliance	Health Boards	Quantifiable	GIRFT principles JAG accreditation
	Provide more robust and in-depth data and reporting to Health Boards	Health Boards	Qualitative	N/A

Theme	Benefit	Beneficiary	Type	Possible Metrics
	Providing regional sustainability and capacity to allow contingency at other sites.	Health Boards	Quantifiable	Increase in the no. of imaging and endoscopy scans/tests
	Provides opportunities for the future reconfiguration of services at the Health Boards	Health Boards	Qualitative	N/A
	Supports the future of other regional initiatives	Region	Qualitative	N/A
	Positive reputational impact to the Health Boards from patients and Welsh Government from positive outcomes of the initiative	Health Boards	Qualitative	N/A
Improved Patient Experience	Improved patient experience	Patient	Quantifiable	Patient satisfaction scores
	Improved utilisation	Patients / Health Boards	Quantifiable	Utilisation rate
	Increased number of and improved clinical pathways developed and delivered at LHP	Patients / Health Boards	Qualitative	N/A
	Reduced health inequalities	Patient / society	Qualitative	N/A
Delivering a Sustainable Workforce	Develop a skilled and sustainable endoscopy workforce	Staff / Health Boards	Qualitative	N/A
	Improved recruitment and retention across the region	Health Board	Qualitative	N/A
	Opportunities to share best workforce practices across the region	Region	Qualitative	N/A
Providing a Sustainable Estate	Modern fit for purpose compliant facility	Health Board	Quantifiable	WHBN/HTMS BREEAM rating Enhanced facilities
	Community Benefits	Region	Quantifiable	No. local direct full time equivalent (FTE) employees hired or retained. No. of weeks of apprenticeships provided to local staff. Equipment or resources donated to local third sector and civil society organisations Directly funded no. hours volunteering time provided to support local community projects. Direct support and investment provided for people to learn and use Welsh (e.g. interactions and signage). Total amount (£) spent in the local supply chain.
	Reduced waste and single use products	Health Board/Society	Quantifiable	Waste and single use products usage

Theme	Benefit	Beneficiary	Type	Possible Metrics
	Improved recycling	Health Board/Society	Quantifiable	Recycling rates
	Contribute to decarbonisation targets (Net Carbon Zero) with energy efficiency	Health Board / Society	Societal	Energy consumption CO2e
	Contribute to decarbonisation targets with more efficient pathway	Health Board / Society	Societal	CO2e reductions
	Preservation of biodiversity and wetland area due to choice and design of site.	Society	Qualitative	N/A
	Enables and provides meaningful and adequate spaces for future phases of work that are planned	Health Boards	Qualitative	NA
	Provides opportunity for future expansion	Health Boards	Qualitative	NA

The quantification of these benefits is explored within section 7.6 of the Economic Case and realisation plans outlined in section 10.6 of the Management Case.

4.3 Main risks

Risk is the possibility of a negative event occurring that adversely impacts on the success of the delivery of the project and its benefits. Identifying, mitigating and managing the key risks is crucial to successful delivery, since the key risks are likely to be that the project will not deliver its intended outcomes and benefits within the anticipated timescales and spend.

The full quantified capital programme risk register can be found in Appendix 5 and informs the planning contingency. An operational / revenue risk register is also developed to cover those risks that do not have capital implications.

Availability of resources to fund the required regional service developments has been highlighted as a risk to deliverability. The diagnostics programme was working on the basis that the funding would be derived from health board budgets, and additional recurrent funding allocated for regional services and performance improvement is intended to support the developments. However, it has been identified that the resource required for revenue funding exceeds funds currently available to health boards and the recommended course of action is to seek funding support for these new service developments from Welsh Government.

Delivery of value for money is a core underpinning principle and requirement. This is being supported by both the development of a robust service specification and assessment of all options, including commercial, for the delivery of community diagnostic hubs.

The currently identified top programme and infrastructure risks are as set out in the table below:

Table 15 - Top risks (current assessment) C x L = R

Description	Consequence	Likelihood	Rating
Regional engagement to facilitate development of clinically led model	5	4	20
Delayed Welsh Govt approval of OBC	5	4	20
Car parking provision available within site confines results in delayed Planning permission	4	4	16
Approval of SAB resubmission required to support the building phasing	4	4	16
FFE provision exceeds the high-level allowances within the cost plan	4	4	16
Medical equipment provision exceeds the high-level allowances within the cost plan	4	4	16
Last minute issues delay completion of building and handover	5	3	15
Contractor insolvency	5	3	15

4.4 Constraints

Constraints relate to the parameters that the project is working within and any restrictions or factors that might impact on its delivery. These typically include limits on resources and compliance issues. The project is subject to the following constraints:

- facilities must be fit for purpose and have future flexibility/adaptability
- implementation must not negatively impact continuation of current service provision
- the proposed solution must be technically feasible
- it must be delivered within agreed capital and revenue funding.

The project must support regional integration and collaboration and be supported by all 3 Health Boards.

4.5 Dependencies

Dependencies include things that must be in place to enable the project or project phases and typically include links to other projects and funding requirements that are likely to be managed elsewhere.

The project is subject to the following dependencies that will be carefully monitored and managed throughout the lifespan of the scheme:

- Availability of Welsh Government funding for both capital and revenue
- Approval from Welsh Government, IIB and other health boards
- Continued support for proposed service model and successful procurement process leading to the appointment of the managed service provider for diagnostics.
- Access to pathology, particularly for endoscopy services. There is a recognised regional capacity gap for pathology. The Regional Diagnostics Programme includes a pathology project whose current main focus is the development of cellular pathology.
- A national business case for digital cellular pathology is a key enabler for regional cellular pathology development and the maintenance of cellular pathology services, as training moves away from the use of microscopes to processing digital samples. The national business case is

awaited, and the regional programme has links to the National Diagnostics Programme to ensure that the digital cellular pathology business case is considered. This will have revenue cost implications for health boards.

- Digital developments including changes to e-referral forms and information flows for reporting to ensure the proposed pathways for regional services are appropriately connected to health board systems. These interdependencies are identified and worked through by digital experts supporting the specification development and where changes are required to systems, these are highlighted to the Directors of Digital Services through the regional portfolio governance structure and support mechanisms.

Economic Case

5 Options identification and appraisal

5.1 Potential scope of services

This section of the business case identifies the scope of the project in terms of the key service requirements that should be considered in designing the future service model and developing options. The case for purchase of the site identified the following services as being integral to the creation of the Phase 1 elective diagnostic hub:

- Diagnostic Imaging Capacity – MRI, CT, Ultrasound and potential X Ray
- Provision of a regional Endoscopy Academy for training
- Endoscopy

These services constitute the core services required for delivery of a diagnostic hub on the LHP site. In terms of deliverability, currently the Health Board, is involved in a procurement exercise to appoint a partner for the delivery of the community diagnostic hub (CDH).

The proposal is that the partner will provide diagnostic services comprising both imaging and endoscopy in the CDH. The ongoing procurement will appoint a partner to provide the services on the LHP site with an option to create facilities on future sites. The CTMUHB CDH is the only one proposed to include regional endoscopy services as well as accommodating an endoscopy academy.

The current design combines capacity to meet the forecast level of demand when the centre opens but with an opportunity to further expand to meet further growth or changes in health screening requirements. The ability to easily absorb and accommodate demand increases gives LHP a unique position of being future ready at the day of opening and the ability to respond quickly and directly to ongoing service pressures.

5.2 CDH - Clinical service delivery options

In November 2022, prior to the full implementation of the Regional Diagnostics Programme a clinical summit was held with representatives of the clinical body from each of the region's health boards. At this point there was agreement on the aims and objectives of the regional working, which were subsequently built into the Project Initiation Document and approved by the Project and Programme Board.

To achieve the stated aims of the business case, the options are required to ensure that:

- Delivery is more accessible to residents living in areas of socio-economic deprivation and able to deliver to more than one health board population in the region.
- Developments deliver an increase in capacity.
- Developments will be founded on seeking sustainable solutions to demand backlogs.

To align with other programmes within the South East Wales Regional Portfolio, the criteria for assessment used for the regional ophthalmology programme for the cataracts interim solution were reviewed and expanded for use to assess the options for radiology service developments. The criteria agreed for the option appraisal were:

- Strategic viability (does it fit with the local and regional plans?)
- Does this option meet the service demand requirements?
- Will this deliver sustainable diagnostic services?

- Clinical viability (can the option deliver the procedures included in the service specification?)
- Operational viability (can this be operational within project timeframes?)
- Workforce viability: does this option:
  - Support sustainable workforce?
  - Deliver on national strategy?
  - Facilitate training?
  - Have implications for existing workforce?
- Estates viability (would this option facilitate the appropriate spaces, e.g. clinic rooms and outpatients space?)
- Financial viability (are the revenue and capital costs reasonable?)
- Geographic suitability / accessibility.

Stage 1 of the consideration of options for regional collaboration was to develop and test a range of potential models. The long list of model options for appraisal was developed in spring 2023 to inform the Project Initiation Document and were reviewed by the Programme Board in a Position Statement to the April 2023 Board. The outcome of this initial appraisal was that community diagnostic hubs and changes to existing practices in collaboration were to be considered further. There was recognition of the potential benefits of the CDH model based on the literature, as set out in the Strategic Case.

During 2023, this long list has been reviewed collaboratively through the clinical and operational leads group against an agreed set of criteria and subsequently tested by each health board prior to consideration by project and programme boards.

Further consideration of appropriate service models have been undertaken by ABUHB as part of the assessments which led to the development of a business justification case for a community diagnostic hub, managed wholly in-house within the NHS (and enabled by the establishment of a second MRI scanner at the Grange University Hospital), which is intended to be located within an existing community services setting. The business justification case sits alongside the regional business case for a managed service contract, with the intention that a community diagnostic hub initiated in the ABUHB area would be geographically accessible to C&VUHB and CTMUHB residents as per the agreed programme aims and principles.

The options considered by the regional Project Board are set out below.

Option 1	**Do nothing** - Health boards would continue to provide services as per current arrangements.
Option 1a	**Different approach to the use of existing services** in each health board, and work toward collaboration through shared processes. Health board expansion of internal capacity and/or other forms of regional working.
Option 2	**Independent Community Diagnostic Hubs (CDH)** – each health board operating their own CDH with no cross-border treatments.
Option 3	**Regional Community Diagnostic Hubs** – a minimum of one per health board, delivering cross-border diagnostic treatment.
Option 4	**A single Regional Radiology Diagnostic centre**, located on one site, serving all three health boards.
Option 5	**Combined approach** - Regional Diagnostic Centre/community diagnostic hubs.
Option 6	**Community Diagnostic Hub with Mobile Units** – as option 3 but with mobile units attached to reach outlying communities through community diagnostic clinics.

Assessment by the clinical and operational leads resulted in a short-list of model options for consideration by the Project Board. The shortlist included three options:

- **1a** – different approach to the use of existing services
- **3** – Community diagnostic hubs (CDH) with a minimum of one per health board area, and
- **6** – Community diagnostic hubs with the option of mobile units.

The Project Board considered these options formally on 23 January 2024 and confirmed the acceptability of both **Option 3** and **Option 6** with the preferred option of development of a community diagnostic hub model for the region, which may incorporate mobile units, as required.

Potential options for the CDH delivery model include the following, which have been tested on the basis of timely delivery, financial delivery and through the site identification and appraisal:

- Repurposing existing estate in the community, staffed by NHS workforce.
- Repurposing existing estate in community, staffed by commercial provider.
- New build (capital), staffed by NHS workforce.
- New build (capital), staffed by commercial provider.
- Partnership with commercial provider (estate and workforce solution).

5.3 Site and infrastructure delivery options

The purpose of the Options Analysis is to identify and appraise the options for the delivery of project and to recommend the option that is most likely to offer best value for money.

However, in this instance this section will not undertake a traditional options appraisal using the business case framework, which is an approach that has been agreed with colleagues in the Capital and Estates team in Welsh Government (WG).

The reasons for this centre on the fact that on purchase of the site a case for purchase was prepared and resulted in approval of capital funds to enable the same. The funding was made on the condition that CTMUHB collaborated with other NHS organisations to develop the site as part of a regional approach to the delivery of services. Therefore, consideration of alternative site options is not relevant.

The services included at this business case stage are the same as those included in the original case for the purchase of the site, with some small changes to the numbers of the same, in line with demand and capacity modelling provided in Section 3 of this case. In addition, after purchase, regional partners were asked to nominate desired alternative or additional services to be included at LHP; no changes or additions to the scope of services were requested or proposed at this time.

As a result, this section will not consider alternative options for service change with the scope and scale having been proven in the sections above. In addition, following WG approvals, design work has already progressed beyond the traditional stage for an OBC, with WG approval to proceed to RIBA 3 given in December 2024. RIBA 3 has completed for Phase 1 and to maintain programme, RIBA 4 works have also commenced.

The RIBA 2 design work was subject to scrutiny by Shared Services Specialist Estates and considered only the **preferred new build infrastructure option**. Scrutiny on the RIBA 2 phase closed on 18 December and approval to proceed to RIBA 3 was given on that date.

In addition to above funding, WG approval was granted to proceed with the demolition of the existing buildings on 31 January 2025, with planning licence approval granted on 2 April 2025.

These works have commenced under a separate contract to the main design works and are programmed to complete by 16 September 2025. As a result, there is no scope to further consider infrastructure and build options.

Finally, a main contractor for completion of the design phase was appointed on 28 March 2025. This appointment was made after a lengthy tender process utilising the Crown Commercial Services Framework under 2 lots to encourage bidders from both pure modular and other off site construction backgrounds to develop the more beneficial construction solution for LHP.

The tender process demonstrated a modular form of MMC was preferred and WG approval to enter into the design contract was received on 14 March 2025. As a result, the build methodology has also been fully determined. Therefore, the economic appraisal in following sections will focus on the delivery options for the CDH only in terms of the scope of the agreement with the third party provider.

6 Economic Appraisal

6.1 Introduction

The purpose of the economic appraisal is to evaluate the costs, benefits and risks of the shortlisted options to identify the option that is most likely to offer best public value for money. In line with current Welsh Government Better Business Case and HM Treasury Green Book project business case guidance, this involves:

- Estimating the capital and revenue costs for each option.
- Undertaking an assessment of benefits and risks for each option, wherever possible quantifying these in monetary-equivalent values.
- Using the DHSC's Comprehensive Investment Appraisal (CIA) Model to prepare discounted cash flows and estimate the Net Present Social Value (NPSV) and Benefit Cost Ratio (BCR) for each option.
- Presenting the results, including sensitivity analysis, to determine the preferred option.

As per Section 5 above, for the purposes of this case, the scope of the **do something** options is all the same (outlined in 5.3), with only how the service is delivered differing. As agreed, as part of the Strategic Overview, there are no other scope options viable for consideration.

6.2 Summary of Phase 1 service delivery options

Whilst the decision has been made to appoint an independent service provider to deliver the model in the CDH, there are options about the extent to which this can be delivered by the partner. As a result, this has been the focus of a more detailed option appraisal with the key options being:

Table 16 - Phase 1 service delivery options summary

Components	**Option 1 -** Fully outsourced managed service contract	**Option 2** (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	**Option 3 -** Traditional capital build and equip + ISP deliver services via managed service contract	**Option 4 -** Traditional capital build and equip + NHS staffing and service provision
Building	ISP Design and Build (Costs captured through revenue costs)	NHS Design and Build (WG Capital Funding)	NHS Design and Build (WG Capital Funding)	NHS Design and Build (WG Capital Funding)
General Building Equipment	ISP Design and Build (Costs captured through revenue costs)	NHS Design and Build (WG Capital Funding)	NHS Design and Build (WG Capital Funding)	NHS Design and Build (WG Capital Funding)
Specific Service Delivery Equipment – First 10 Years after completion of LHP	ISP provide and maintain (Costs captured through revenue costs)	ISP provide and maintain (Costs captured through revenue costs)	NHS Provide and Maintain (WG Capital Funding)	NHS Provide and Maintain (WG Capital Funding)
Specific Service Delivery Equipment – After 10 years	NHS Provide and Maintain (WG Capital Funding)	NHS Provide and Maintain (WG Capital Funding)	NHS Provide and Maintain (WG Capital Funding)	NHS Provide and Maintain (WG Capital Funding)
Service Delivery (Staffing) – First 10 Years after completion of LHP	ISP Staffing	ISP Staffing	ISP Staffing	NHS Staffing

Components	**Option 1 -** Fully outsourced managed service contract	**Option 2** (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	**Option 3 -** Traditional capital build and equip + ISP deliver services via managed service contract	**Option 4 -** Traditional capital build and equip + NHS staffing and service provision
Service Delivery (Staffing) – After 10 Years	NHS Staffing	NHS Staffing	NHS Staffing	NHS Staffing
Lifecycle Costs – First 10 Years after completion of LHP	N/A	Building Lifecycle Costs	Building Lifecycle Costs	Building Lifecycle Costs
Lifecycle Costs – After 10 years	NHS (WG Capital Funding) buys building buy back at net book value after 10 years. Building Lifecycle and equipment replacement Costs	Building Lifecycle and equipment replacement Costs	Building Lifecycle and equipment replacement Costs	Building Lifecycle and equipment replacement Costs

6.3 Capital costs

Capital costs for construction of phase 1 of the LHP have been estimated and prepared for the Preferred Way Forward (Option 2) by the Health Board's Cost Advisors, Mott Macdonald using the following assumptions:

- Agreed Schedules of Accommodation and RIBA 3b design. Agreed scope of Phase 1 to cover the build of the CDH plus additional site wide infrastructure to facilitate later phases
- Proposed start on site 26 February 2026 and proposed construction completion date of July 2027 (though final commissioning continues until the end of October 2027).
- Works costs calculated using benchmarked rates suitable for South Wales (including Healthcare Premises Cost Guide) @ BCIS TPI updated 20/08/2025
- Allowances for fees, equipment costs, planning contingency have been applied as appropriate.
- No allowance for optimism bias has been applied given the degree of certainty at this stage in terms of maturity of design, knowledge of the site, and publicly declared political support for the development. It is therefore superseded by the Costed Risk Register figure.

The capital costs for Options 3 and 4 are the same as Option 2, except for an adjustment made to the equipment costs, to account for these options providing specific service delivery equipment. This has a flow on effect to the Quantified Risk Contingency and VAT. The value of the equipment has been estimated by the Health Board, with a full breakdown of the equipment and costs provided in appendix 10 (CIA Model).

The resulting capital costs estimates are summarised in the table below and a copy of the detailed capital cost form for Option 2 is provided in Appendix 8.

Table 17 - Initial capital costs

Element, £'000	Option 0 - BAU	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
Works Costs	-	-	58,058	58,058	58,058
Fees	-	-	14,463	14,463	14,463
Non-Works Costs	-	-	10,362	10,362	10,362
Equipment Costs	-	-	2,628	11,483	11,483
Quantified Risk Contingency	-	-	10,583	11,680	11,680
Subtotal	**-**	**-**	**96,094**	**106,046**	**106,046**
VAT	-	-	13,895	15,666	15,666
Total capital costs (as per capital cost forms)	**-**	**-**	**109,989**	**121,712**	**121,712**
Exclude sunk costs	-	-	-15,123	-15,123	-15,123
Exclude Inflation adjustment to rebase to base year	-	-	-2,553	-2,553	-2,553
Exclude VAT	-	-	-13,895	-15,666	-15,666
Total capital costs (for Economic Case)	**-**	**-**	**78,417**	**88,369**	**88,369**

It should be noted that, in accordance with HM Treasury Green Book guidance, these costs have been adjusted for the purposes of the economic appraisal as follows:

- Exclude sunk costs
- Exclude VAT
- Are restated at base year prices.

6.4 Lifecycle capital costs

Ongoing investment requirements reflect the whole life costs of replacing, refurbishing or upgrading of assets over the lifetime of the appraisal period.

Building lifecycle costs across the appraisal period have been estimated for Options 1-4 using lifecycle figures provided by the Health Board's Cost Advisors, Mott Macdonald. It is also expected that both general and specific service delivery equipment will be replaced every 10 years in every "do something" option. Further refinement of lifecycle costs will be provided at FBC stage.

Further to this it is assumed in Option 1, at the end of the managed service contract the Health Boards would have to buy back the building from the provider at the assumed net book value.

A breakdown of the current estimation of lifecycle costs across the whole appraisal period is provided in the table below:

Table 18 - Lifecycle Costs

Lifecycle Costs, £'000	Option 0 - BAU	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
Building Buy Back Costs	-	61,457	-	-	-
Building lifecycle Costs	-	106,361	112,821	112,821	112,821
Equipment replacement costs	-	57,413	57,413	57,413	57,413
Total lifecycle costs - Full appraisal period	-	**225,232**	**170,234**	**170,234**	**170,234**

6.5 Recurring revenue costs

6.5.1 Assumptions

Recurring revenue costs for the period of the managed service contract (10 years) for each option has been estimated using the following assumptions:

Option 1 - Fully outsourced managed service contract

- No pay costs
- No non-pay costs
- Healthcare Services costs calculated by: 2025-26 Tariff price of scan/test with a 5% market forces factor applied multiplied by amount of activity of relevant scan/test.
- Assumed additional rental costs for the endoscopy Skills Academy space which is estimated at a daily rental cost of £6,000 based on indications from providers.

Option 2 - Traditional capital build + ISP equip and deliver services via managed service contract

- No pay costs
- No non-pay costs
- Healthcare Services costs calculated by:
  - 2025-26 Tariff price of scan/test with a 5% market forces factor applied multiplied by amount of activity of relevant scan/test.
  - Applying a 20% tariff discount due to the Health Boards providing the LHP land and building.

Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract

- Pay costs for site-based staffing (i.e. receptionists etc.)
- Non-pay costs for imaging, endoscopy and site-based elements, including supplies, utilities, equipment maintenance etc.
- Healthcare Services costs calculated by: Assumed cost of managed services contracted staffing.

Option 4 - Traditional capital build and equip + NHS staffing and service provision

- Pay costs for cost of using NHS staff to provide the imaging and endoscopy.
- Non-pay costs for imaging, endoscopy and site based elements, including supplies, utilities, equipment maintenance etc.
- No Healthcare Services costs

6.5.2 Recurring revenue costs summary

The annual impact on each option for the period of the managed service contract (10 years) is summarised in the table overleaf. It is assumed that costs will be incurred from the start of 2027-28 for each option. More detailed calculations are provided in Appendix 9 and 10.

Table 19 - Annual revenue costs during managed service contract period (first 10 years post implementation)

Element, £'000	Option 0 - BAU	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
Pay Costs	-	-	-	324	2,788
Non-Pay Costs	-	-	-	3,313	2,587
Healthcare Services (cost of managed service contract)	-	9,341	7,473	3,780	-
Rental Payment for Endoscopy Skills Academy	-	2,190	-	-	-
Total annual revenue costs	-	**11,531**	**7,473**	**7,417**	**5,376**
Incremental Impact on Annual Revenue Costs	-	*11,531*	*7,473*	*7,417*	*5,376*

After the end of the managed services contract, it is assumed that the service will come in house and all options will have Option 4's recurring revenue costs.

A breakdown of the annual revenue costs after the managed service contract period is outlined in the table below:

Table 20 - Annual revenue costs post managed service contract period

Element, £'000	Option 0 - BAU	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
Pay Costs	-	2,788	2,788	2,788	2,788
Non-Pay Costs	-	2,587	2,587	2,587	2,587
Total annual revenue costs	-	**5,376**	**5,376**	**5,376**	**5,376**
Incremental Impact on Annual Revenue Costs	-	*5,376*	*5,376*	*5,376*	*5,376*

It should be noted that, in accordance with HM Treasury Green Book guidance, these costs exclude capital charges such as depreciation and therefore differ from the total figures in the Finance Case.

6.6 Transitional costs after the end of managed service contract period

It is expected that after the end of the managed service contract period for Option 1, due to it being a complete handover, there would be 6 months of dual running costs while the inhouse service ramps up, this would equate to c.£4.7m in 2037/38.

It is not expected that there would be any significant transitional costs in any of the other options.

6.7 Benefits analysis

6.7.1 Approach

As outlined in sections 5.2 and 5.3 of the Strategic Case, a systematic approach has been undertaken to develop the benefits analysis, which involved establishing the benefits case and identifying measurable benefits, and metrics.

Figure 14 - Benefits analysis approach

As part of the Economic Case, these benefits must be quantified to enable a robust value for money analysis to be undertaken, using the following categories.

Figure 15 - Benefits categories

An initial quantified benefits analysis has therefore been prepared based on the baseline and benchmarking data that is available at this stage. Every effort has been made to quantify the benefits for the OBC and, where possible, they have been stated in monetary equivalent values. Further work will continue into the FBC stage to validate assumptions, collate missing data and identify key baselines, as well as exploring benefits which have not yet been quantified.

6.7.2 Benefits assumptions

An overview of the main benefits that it is anticipated will be delivered as a result of the LHP, along with the key assumptions used to quantify them, is provided in the table overleaf. Detailed calculations are available in Appendix 6.

Table 21 - Overview of LHP benefits

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
Creation of diagnostics centre						
Increased Imaging capacity	Additional scans undertaken	N/A	TBC (26,000 scans provided at LHP by the managed service)	Not monetisable	To be confirmed exact extent but it is assumed a portion of the imaging capacity will be a transfer of current capacity, but the vast majority will be additional capacity. This helps with freeing up space in acute settings for emergency care patients and pathways. (Likely an additional benefit) – Could look at same day emergency care no. of scans (delays over a week for scans and reporting) Helps to focus on emergency work.	UB1 (a)
Increased Endoscopy capacity	Additional tests undertaken	N/A	11,330 additional endoscopy tests at LHP	Not monetisable	The increased endoscopy capacity will be additional to current levels.	UB1 (b)
Reduced Imaging waiting times as a result of additional capacity provided by the diagnostics centre.	% of patients waiting over 8 weeks for Imaging	47% (CTMUHB % as of January 2024. Source: Strategic Overview Case 2025)	0% (In line with NHS Wales target wait times)	Not monetisable	Comparators • NHS England's planning guidance for 2024/25 requests that the percentage of patients waiting 6 weeks or more should be at most 5%. • NHS Wales target is that the maximum wait for access to specified diagnostic tests is 8 weeks. The target improvements will be incorporated into the managed service contract as KPI's meaning there will be a high degree of certainty that the improvement will be reached.	UB2 (a)
Reduced Endoscopy waiting times as a result of additional capacity provided by the diagnostics centre.	% of patients waiting over 8 weeks for Endoscopy	64% (Average for 3 UHBs in August 2024. Source: Regional Endoscopy Plan 2025)	0% (In line with NHS Wales target wait times)	Not monetisable		UB2 (b)
Release of elective diagnostic capacity at Acute sites, which can be used for urgent and emergency care patients/pathways. This would lead to reduced waiting times for urgent scans and subsequent reports.	No. of scans undertaken in SDEC Wait time/Delays for scan and or reporting from scan in SDEC/Acute settings	To be confirmed at FBC	To be confirmed at FBC	Not Monetisable	The additional capacity provided at LHP will free up capacity at acute sites for urgent and emergency patients requiring scans/tests. This will lead to more prompt turnaround of scans and subsequent reporting. Measures included as potential ways to measure this benefit, but quantification will be completed at FBC stage.	UB3

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
Supports greater compliance with cancer pathways: By providing earlier diagnosis which will allow more targeted interventions and better monitoring.	Single suspected cancer pathway (SCP) compliance: 62-day backlog %age of patients starting treatment within 62 days	58% Equates to 444 patients waiting longer than 62 days (Source: CTMUHB)	80% Equates to c.211 patients waiting longer than 62 days (In line with national target)	Contributes to SB1	National target of at least 80% of people starting first definitive treatment for cancer within 62-days as per NHS Wales planning framework 2025 to 2028, Annex 1: key delivery expectations (NHS Wales planning framework 2025 to 2028 | GOV.WALES) The target improvements will be incorporated into the managed service contract as KPI's meaning there will be a high degree of certainty that the improvement will be reached.	UB4
	SCP compliance: 104-day backlog	130 patients waiting longer than 104 days (Based on a 2024-25 average Source: CTMUHB.)	39 patients waiting longer than 104 days (In line with CTMUHB Target for March 2026)	Contributes to SB1	104-day backlog targets in line with CTMUHB Target. The target improvements will be incorporated into the managed service contract as KPI's meaning there will be a high degree of certainty that the improvement will be reached.	UB5
Improved patient outcomes: Earlier diagnosis of cancers leading to more targeted interventions and better monitoring will contribute to improved mortality rates	Single suspected cancer pathway (SCP) compliance: 62-day backlog %age of patients starting treatment within 62 days	58% Equates to 444 patients waiting longer than 62 days (Source: CTMUHB	80% Equates to 211 patients waiting longer than 62 days (This equates to an assumed 16 QALYs p.a. based on 24 patients benefit from earlier cancer diagnosis as result of achievement of SCP compliance 62-day backlog targets)	£3.4m p.a. after confidence rating applied	Based on figures provided by Cancer Research UK in written evidence to the UK parliament on 4 common types of cancer, the average 10-year survival rate when diagnosed at the earliest stage is 78% compared to 10% at the latest stage. Percentage of suspected cancer referrals to cancer diagnosis was 10% based on data from NHS England Cancer Waiting Times Feb 2024-25 It is therefore assumed for the c.233 patients who receive an earlier diagnostic test (due to - achievement of SCP compliance 62-day backlog targets outlined in UB1), 24 will receive a cancer diagnosis. As a result of the earlier diagnosis, those 24 patients will have increased their 10-year survival rate by 68%. Apply 1 QALY for 10 years to the increased survival rate per patient. QALY value of £70,000 as per HM Treasury Green Book (uplifted to base year prices)	SB1

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
					A prudent 25% confidence rating is then applied noting the significant increase in 10-year survival rate that has been applied, and that it assumes that by achieving the 62-day backlog target, those patients will receive the diagnosis at the earliest stage compared to the latest stage.	
Improved patient outcomes: Earlier diagnosis of other clinical issues (non-cancer related) leading to more targeted interventions and better monitoring will contribute to improved quality of life for patients.	No of additional Endoscopy tests undertaken	N/A	11,330 additional endoscopy tests at LHP	£5.2m after confidence rating applied	Increased number of endoscopy tests will lead to an increase in the number of people with hypertension being diagnosed. This diagnosis will cause the patient to get treatment and management of Hypertension. This will in turn lead to a potential reduction in all-cause mortality by 13% of those diagnosed with hypertension. The following assumptions have been used to calculate a monetary value: • Only focused on the increased number of endoscopy tests (11,330) as these are all additional. • Prevalence of Hypertension in CTM's catchment area is 16.9% (See: https://www.gov.wales/general-practice-disease-registers-interactive-dashboard). • Assume that the additional tests diagnose patients with hypertension in line with prevalence and that 50% of those patients otherwise did not know they had it/was not controlled • It is noted that this is a large assumption, but this is factored into a low confidence rating (outlined below). • No. of additional patients diagnosed with hypertension per year = 957 • This leads to those patients undertaking treatment and controlling it, which reduces the risk of all-cause mortality by 13% (see: https://www.england.nhs.uk/blog/under-control-why-getting-to-grips-with-blood-pressure-is-a-win-win-intervention-for-healthcare-systems/) • Potential reduction in mortality per year is 124.	SB2

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
					• Assume this results in 1 QALY for 10 additional years per reduction in mortality. QALY value of £70,000 as per HM Treasury Green Book (uplifted to base year prices) A prudent 5% confidence rating is then applied noting there are significant assumptions within the calculation including that a significant no. of patients that are tested are not already aware they have hypertension and that as a result of knowing there will be a significant reduction in mortality that does not take into account other factors.	
Release of capacity at acute sites to undertake Bowel cancer screenings.	No. of Bowel Cancer Screenings undertaken at acute sites	To be confirmed at FBC	To be confirmed at FBC	To be confirmed at FBC (potentially monetisable)	To be confirmed at FBC	SB3
Reduced reliance on external Diagnostics capacity: Reduced outsourcing, insourcing and waiting list initiatives as a result of additional capacity provided by CDC	Expenditure on Diagnostics outsourcing, insourcing and waiting list initiatives	N/A	N/A	Included in BAU costs	Included in the transfer of costs associated with substitution of services at CTMUHB. It should be noted that the LHP and the managed service contract has been built/developed so that additional capacity can be accommodated. This would mean that if there was an increase in the capacity required it could be managed without having to rely on relatively more expensive and shorter term outsourcing, insourcing and waiting list initiatives. Note FBC Actions include verify whether the other UHBs can reduce costs / all 3 UHBs can reduce the risk of these costs as a result of LHP.	N/A
Assist with meeting 'Straight to Test' guidance.	No. of direct referrals from GPs to Radiology	TBC	TBC	TBC	LHP will increase the ability to have direct referrals from GP to radiology will help meet the Straight to Test guidance. This will also improve waiting list cleanliness because it will help to ensure that the lists only have the necessary patients who require the service on them.	UB6

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
Model of care transformation						
Greater alignment with GIRFT principles	GIRFT principles	To be confirmed at FBC	To be confirmed at FBC	Not monetisable	N/A – Will help all of the other sites to align with GIRFT principles.	UB7
Achievement of JAG accreditation	JAG accreditation	To be confirmed at FBC	Achieve JAG accreditation (minimum contract requirement)	Not monetisable	N/A – Will help all of the other sites to reach JAG accreditation.	UB8
Provide more robust and in-depth data and reporting to Health Boards: the managed service can provide more robust and in-depth data to the Health Boards which can be used to better inform decisions.	Qualitative	N/A	N/A	Not Monetisable	Not possible to quantify in a meaningful way at this stage	UB9
Providing regional sustainability and capacity to allow contingency at other sites.	Increase in the no. of imaging and endoscopy scans/tests	N/A	26,000 imaging scans provided at LHP by the managed service and 11,330 additional endoscopy tests at LHP	Not monetisable	As a result of the increased capacity at LHP it will provide regional sustainability and contingency at other acute sites.	UB10
Provides opportunities for future reconfiguration of services at the 3 UHBs: The move of diagnostic activity to LHP will release regional capacity, providing the UHBs opportunities to consolidate or reconfigure services for future rationalisation	Qualitative	N/A	N/A	Not Monetisable	Not possible to quantify in a meaningful way at this stage	UB11
Supports other regional initiatives: Delivery of a successful regional model provides an evidence-base and acts as a potential exemplar, providing a catalyst for standardising other suitable pathways or centralising other suitable services	Qualitative	N/A	N/A	Not Monetisable	Not possible to quantify in a meaningful way at this stage	UB12

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
Positive reputational impact to UHBs from patients and Welsh Government from positive outcomes of the initiative	Qualitative	N/A	N/A	Not Monetisable	It is assumed that the investment and service will be delivered in a productive and beneficial manner which will provide positive outcomes for patients, staff and the organisations. This will lead to a positive reputational impact from both patients and Welsh Government.	UB13
Improving patient experience						
Improved patient experience as a result of reduced waiting times, ease of access and quality of care.	Patient satisfaction scores	N/A (not possible to isolate existing patient scores from wider UHB)	95% (Based on current targets)	Not monetisable	N/A	UB14
Ability to achieve better utilisation as result of confidence in level of booking: Centralised elective centre with co-location of equipment and clinical rooms making it a “one-stop” clinic provides predictability of care and planning.	Utilisation rate	To be confirmed at FBC	To be confirmed at FBC	Potentially monetisable – to be explored at FBC	Due to LHP being a centralised elective centre, there would be more confidence in how many elective scans will be utilised and hence how many should be booked, leading to better utilisation. This would be a benefit to both the Health Boards and patients and would assist with reducing wating times and throughput.	UB15
Increased number of and improved clinical pathways developed and delivered at LHP	Qualitative	N/A	N/A		Due to LHP being a centralised elective centre and a “one-stop” clinic, it will lend itself to developing and delivering more and improved clinical pathways. These pathways and improved ways of working could be used as an exemplar and then also be rolled out across the region.	UB16
Reduced health inequalities Reduction in waiting times and ease of access supports equality of access	Qualitative	N/A	N/A		Not possible to quantify in a meaningful way at this stage	UB17

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
Delivering a sustainable workforce						
Develop a skilled and sustainable endoscopy workforce: The new Skills Academy in partnership with HEIW at LHP will train and develop a skilled endoscopy workforce that can provide high quality endoscopy service.	Qualitative	N/A	N/A	Not monetisable	The skills academy in partnership with HEIW will provide training opportunities to help develop a highly skilled and sustainable endoscopy workforce, so that at the end of the managed services contract LHP can be staffed adequately and provide high quality endoscopy services. The skills academy in partnership with HEIW will provide improved access to consistent, high-quality training programmes to ensure uniform competencies among endoscopy practitioners. Due to the network of regional training centres provided by HEIW, best practices can also be shared across the region. It will also encourage collaboration among healthcare professionals to enhance team-based care in endoscopy services It should be noted that currently there are endoscopy workforce challenges including risk that a significant portion of the workforce may retire in the short to medium term, meaning that development of staff to replace them is of a high priority. Although it is assumed that should there be the opportunity for the transfer of some staff into opportunities at LHP after the end of the managed service contract this would be incidental. The main goal and benefit would be in partnership with HEIW to develop an endoscopy workforce during the period of the managed services contract that would be able to manage the service at the end.	UB18
Improved recruitment and retention across the region due to the improved training and development provided at LHP as well as from reduced pressure on acute sites as a result of increased capacity at LHP.	Qualitative	N/A	N/A	Not monetisable	It is expected that as a result of the improved opportunities for training and development at LHP that would be available for endoscopy workforce across the region, this will lead to improved recruitment and retention across the region (from opening). It is also expected staff at Acute sites will have reduced pressure on them from the increased capacity at LHP, which will lead to staff being able to provide timelier service to patients at those acute	UB19

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
					sites, which in turn should lead to less complaints/concerns and a better place to work, contributing to improved recruitment and retention. It is also expected that after the end of the managed service contract, there will be significant and desirable new opportunities for colleagues to continue providing the service at LHP.	
Opportunities to share best workforce practices across the region	Qualitative	N/A	N/A	Not monetisable	Learnings around more efficient ways of workings can be taken from the managed diagnostics service. This will lead to optimised workforce planning and a team that can operate in a more agile way is expected to result in productivity improvements and rota efficiencies	UB20
Providing a sustainable estate						
Modern fit for purpose compliant facility that aligns with current guidance and provides more robust, resilient and sustainable facilities	WHBNs HTNs	N/A	Complies with relevant WHBNs and HTNs	Not monetisable	N/A	UB21
	BREEAM rating	N/A	BREEAM rated as excellent	Not monetisable	N/A	UB22
	Enhanced facilities	N/A	Enhanced facilities enhanced provisions (i.e. 2 oxygen tanks, N+N generator etc.)	Not monetisable	N/A	UB23
Community Benefits (Social Value provided by the contractor))	Number of local direct full time equivalent (FTE) employees hired or retained.	N/A	10 FTE	Not monetisable	Target as per Social Value information provided as part of the Tender documents by MTX.	UB24 (a)
	Number of weeks of apprenticeships provided to local staff.	N/A	250 weeks	Not monetisable	Target as per Social Value information provided as part of the Tender documents by MTX.	UB24 (b)
	Equipment or resources donated to local third sector and civil society organisations	N/A	£25,000 donated	Potentially monetisable	Target as per Social Value information provided as part of the Tender documents by MTX.	UB24 (c)

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
	Directly funded number of hours volunteering time provided to support local community projects.	N/A	250 Hours of volunteering time	Not monetisable	Target as per Social Value information provided as part of the Tender documents by MTX.	UB24 (d)
	Direct support and investment provided for people to learn and use Welsh (e.g. interactions and signage).	N/A	£25,000	Potentially monetisable	Target as per Social Value information provided as part of the Tender documents by MTX. Allocate £25,000 to support the Welsh language on a construction project by offering free Welsh lessons for workers, tailored to industry vocabulary (£12k). Introduce bilingual site signage, safety instructions, and manuals (£7k). Host community engagement events, such as guided tours and Welsh-themed workshops, in partnership with local schools or organizations (£5k). Celebrate Welsh culture onsite with events and competitions like St. David's Day (£1.5k). Leave a legacy with bilingual plaques or contributions to local Welsh programs (£1.5k). Partner with Mentrau Iaith or Learn Welsh Cymru for effective delivery and long-term impact, promoting Welsh language use onsite and beyond.	UB24 (e)
	Total amount (£) spent in the local supply chain.	N/A	£20,000,000 spent locally	Not Monetisable	Target as per Social Value information provided as part of the Tender documents by MTX. Potential social value generated by value spent locally = £20,000,000*1.76 (Local Multiplier) = £35,200,000. Note will not be included as a monetisable value in the CIA Model.	UB24 (f)
Reduced waste and single use products: Contribute to CTMUHB environmentally sustainable goals by reducing waste and single use products	Waste and single use products usage	TBC at FBC	TBC at FBC	TBC at FBC	TBC at FBC (however examples include the Gloves off initiative)	UB25

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
Improved recycling: Contribute to CTMUHB environmentally sustainable goals by improved recycling and finding alternative ways of disposing of waste	Recycling rates	TBC at FBC	TBC at FBC	TBC at FBC	TBC at FBC	UB26
Contribute to decarbonisation targets (Net Carbon Zero) with energy efficiency: Providing an energy efficient building which optimises energy consumption and associated CO2e	Energy consumption CO2e	No baseline available as new facility	TBC at FBC	TBC at FBC	TBC at FBC	UB27
Preservation of biodiversity and wetland area due to choice and design of site.					As a result of the choice of site for the development and that is recycling a previously developed industrial site instead of a greenfield site, there is preservation of biodiversity in the region. The choice of design and ensuring it stays within the already developed portions of the site, the wetland area is preserved and protected from all development in line with Local Council's recommendations.	
Enables and provides meaningful and adequate spaces for future phases of work that are planned	Qualitative	N/A	N/A	Not monetisable	Not possible to quantify in a meaningful way at this stage	UB28
Provides opportunity for future expansion: As a result of the choice of site and design, it allows for expansion to capacity in current services as well as development of future services	Qualitative	N/A	N/A	Not monetisable	Not possible to quantify in a meaningful way at this stage Existing design allows for future increase in capacity (i.e. has design has factored in space for further equipment and rooms to accommodate providing additional capacity in the future)	UB29

6.7.3 Monetisable benefits analysis

While work continues to validate assumptions and explore benefits that it has not yet been possible to quantify, initial analysis has identified circa £8.6m of monetisable benefits per year, as summarised in the table below.

Table 22 - Monetisable benefits values after confidence rating (when benefits are fully realised)

Element	Option 0 – BAU £'000	All "Do Something" Options £'000
Cash releasing benefits	0	0
Non-cash releasing benefits	0	0
Societal benefits	0	8,619
Total annual recurring benefits values	**0**	**8,619**

These figures can be considered risk-adjusted since, as outlined in Table 22 above, relatively prudent confidence ratings have been applied to them to reflect the degree of uncertainty at this stage in the process. Further work will be undertaken at FBC to firm up these assumptions and reduce the level of uncertainty.

6.7.4 Unmonetisable benefits analysis

In addition to the monetisable benefits there are several benefits which it is not possible to monetise at this stage, either because they cannot be meaningful quantified or because they cannot be stated in monetary terms. A summary is provided below.

Table 23 - Unmonetisable benefits analysis

Ref	Description	Option 0 - BAU	All "Do Something" Options
UB1 (a)	Increased Imaging capacity	-	TBC (26,000 scans provided at LHP by the managed service)
UB1 (b)	Increased Endoscopy capacity	-	11,330 additional endoscopy tests at LHP
UB2 (a)	Reduced Imaging waiting times	-	Percentage patient wait times for imaging of greater than 8 weeks will reduce from 47% to 0% for CTMUHB
UB2 (b)	Reduced Endoscopy waiting times	-	Percentage of patient wait times for endoscopy of greater than 8 weeks will reduce from 64% to 0% across the 3 Health Boards
UB3	Release of elective diagnostic capacity at Acute sites, which can be used for urgent and emergency care patients/pathways.	-	To be confirmed at FBC
UB4/5	Supports greater compliance with cancer pathways	-	SCP Compliance = 75% 62-day backlog = 279 patients 104-day backlog = 39 patients
UB6	Assist with meeting 'Straight to Test' guidance.	-	To be confirmed at FBC
UB7/8	Greater alignment with GIRFT principles and achievement of JAG compliance	-	Achieve JAG accreditation (minimum contract requirement)
UB9	Provide more robust and in-depth data and reporting to Health Boards	-	Qualitative
UB10	Providing regional sustainability and capacity to allow contingency at other sites.	-	26,000 imaging scans provided at LHP by the managed service and 11,330 additional endoscopy tests at LHP

Ref	Description	Option 0 - BAU	All "Do Something" Options
UB11	Provides opportunities for the future reconfiguration of services at the three Health Boards	-	Qualitative
UB12	Supports the future of other regional initiatives	-	Qualitative
UB13	Positive reputational impact to the Health Boards from patients and Welsh Government from positive outcomes of the initiative	-	Qualitative
UB14	Improved patient experience	-	95% patient satisfaction
UB15	Ability to achieve better utilisation as result of confidence in level of booking	-	To be confirmed at FBC
UB16	Increased number of and improved clinical pathways developed and delivered at LHP	-	Qualitative
UB17	Reduced health inequalities	-	Qualitative
UB18	Develop a skilled and sustainable endoscopy workforce	-	Qualitative
UB19	Improved recruitment and retention across the region due to the improved training and development provided at LHP as well as from reduced pressure on acute sites as a result of increased capacity at LHP.	-	To be confirmed at FBC
UB20	Opportunities to share best workforce practices across the region	-	Qualitative
UB21-23	Modern fit for purpose compliant facility	-	Complies with WHBN/HTMs BREEAM rated as excellent Enhanced facilities with enhanced provisions (i.e. 2 oxygen tanks, N+N generator etc.)
UB24	Community Benefits (Social Value provided by the contractor))	-	10 local direct full time equivalent (FTE) employees hired or retained. 250 weeks of apprenticeships provided to local staff. £25,000 worth of equipment or resources donated to local third sector and civil society organisations 250 Hours of volunteering time provided to support local community projects. £25,000 direct support and investment provided for people to learn and use Welsh (e.g. interactions and signage). £20,000,000 spent in the local supply chain.
UB25	Reduced waste and single use products	-	To be confirmed at FBC
UB26	Improved recycling	-	To be confirmed at FBC
UB27	Contribute to decarbonisation targets (Net Carbon Zero) with energy efficiency	-	To be confirmed at FBC
UB28	Preservation of biodiversity and wetland area due to choice and design of site.	-	Qualitative

Ref	Description	Option 0 - BAU	All "Do Something" Options
UB29	Enables and provides meaningful and adequate spaces for future phases of work that are planned	-	Qualitative
UB30	Provides opportunity for future expansion: As a result of the choice of site and design, it allows for expansion to capacity in current services as well as development of future services	-	Qualitative

6.8 Risk analysis

The risks for each option have been assessed and, as far as possible, quantified and expressed in monetary equivalent terms, including:

- Quantified risk in relation to planning contingency included in capital cost forms
- Key project risks which have not been accounted for within capital costs.

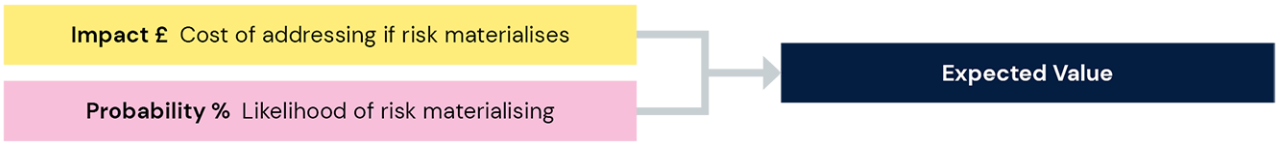
Key project risks have been identified which are not already accounted for within capital costs and these include the following:

- **Funding Risk - Unable to secure sufficient capital funding to deliver the project:** There is a risk that due to the significant amount of initial capital funding required to deliver the project it may take time to secure this funding which could lead to delays in the programme while alternative routes are explored.
- **Funding Risk - Unable to secure sufficient revenue funding to deliver the project:** There is a risk that due to the significant amount of ongoing revenue funding required to deliver the project it may take time to secure this funding which could lead to delays in the programme while alternative routes are explored.
- **Implementation Risk – Increased procurement timescales lead to delays:** There is a risk that the procurement timescales are longer than expected leading to delays in implementation of the project and resulting in the programme having to be extended.
- **Outsourcing Risk – Unable to secure a partner to provide the service:** There is a risk that due to the ISP having to provide the new LHP and to a much lesser extent provide the service that it would be difficult to find a provider that is willing to partner on the project. This could lead to delays in the programme while alternative routes are explored.
- **Workforce Risks – Recruitment and Retention (short term):** There is a risk that in the option where the service would be provided by NHS staff, that it would be difficult to recruit sufficient substantive staff in the short term, which could lead to a reliance on unplanned, expensive temporary and locum staff leading to increased staffing costs.
- **Workforce Risks – Recruitment and Retention (long term):** There is a risk that after the end of the ISP contract period that it would be difficult to recruit sufficient substantive staff, which could lead to a reliance on unplanned, expensive temporary and locum staff leading to increased staffing costs. It should be noted that this risk is significantly mitigated in the options where an ISP provides the service in the short term as that will have given the Health Boards an opportunity to train staff and share learnings ready for the service to be provided by NHS staff.
- **Outsourcing Risk – Increased Handover Costs:** There is a risk that after the end of the ISP contract period, for the fully outsourced option, when the Health Boards purchase the building back from the ISP, the cost of this has been understated, leading to an increased handover payment.

- **Outsourcing Risk – The building that would be provided by the ISP doesn't meet the health Boards' requirements:** There is a risk that the ISP owned building that is handed over to the Health Boards after the end of the ISP contract period does not fully meet the Health Boards requirements due to the Health Boards having less control at design stage. This could lead to increased lifecycle costs for the building.

These risks have been quantified by calculating an 'expected value'. This provides a single value for the expected impact of all risks. It is calculated by multiplying the likelihood of the risk occurring (probability) by the cost of addressing the risk (impact) and summing the results for all risks and outcomes.

Figure 16 - Risk quantification approach using single-point probability analysis



The assumptions included to assess the impact and probability of these risks are outlined in the table below.

Table 24 - Risk assumptions

Element	Option 0 - BAU	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
K1 – Funding Risk: Capital Funding					
Risk	**Unable to secure sufficient capital funding to deliver the project**				
Consequence	**Programme extended to allow time to explore alternative routes**				
Impact per year			Assume a 12-month extension at a run rate of £400k per week, which equals £20.8m	Assume a 12-month extension at a run rate of £400k per week, which equals £20.8m	Assume a 12-month extension at a run rate of £400k per week, which equals £20.8m
Probability			5%	10%	10%
Timescales			Year 0	Year 0	Year 0
Total Risk Value £'000	**Does Not Apply**	**Does Not Apply**	**1,040**	**2,080**	**2,080**
K2 – Funding Risk: Revenue Funding					
Risk	**Unable to secure sufficient revenue funding to deliver the project**				
Consequence	**Programme extended to allow time to explore alternative routes**				
Impact per year		Assume a 12-month extension at a run rate of £400k per week, which equals £20.8m	Assume a 12-month extension at a run rate of £400k per week, which equals £20.8m	Assume a 12-month extension at a run rate of £400k per week, which equals £20.8m	Assume a 12-month extension at a run rate of £400k per week, which equals £20.8m
Probability		30%	10%	10%	10%
Timescales		Year 0	Year 0	Year 0	Year 0
Total Risk Value £'000	**Does Not Apply**	**6,240**	**2,080**	**2,080**	**2,080**
K3 – Implementation Risk: Delays from increased procurement timescales					
Risk	**Implementation is delayed due to increased procurement timescales**				
Consequence	**Programme extended**				
Impact per year		Assume a 12-month extension to the programme at a run rate of £400k per week, which equals £20.8m		Assume a 12-month extension to the programme at a run rate of £400k per week, which equals £20.8m	Assume a 12-month extension to the programme at a run rate of £400k per week, which equals £20.8m
Probability		75%		15%	15%
Timescales		Year 0		Year 0	Year 0
Total Risk Value £'000	**Does Not Apply**	**15,600**	**Does not Apply**	**3,120**	**3,120**

Element	Option 0 - BAU	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
K4 – Outsourcing Risk: Unable to Secure Partner					
Risk	**Unable to secure partner to provide the service**				
Consequence	**Programme extended to allow time to explore alternative routes**				
Impact per year		Assume a 12-month extension to the programme at a run rate of £400k per week, which equals £20.8m	Assume a 12-month extension to the programme at a run rate of £400k per week, which equals £20.8m	Assume a 12-month extension to the programme at a run rate of £400k per week, which equals £20.8m	
Probability		75%	2.5%	5%	
Timescales		Year 0	Year 0	Year 0	
Total Risk Value £'000	**Does Not Apply**	**15,600**	**520**	**1,040**	**Does Not Apply**
K5 – Workforce Risk: Recruitment and Retention (short term)					
Risk	**Unable to recruit sufficient staff to enable delivery of the model in the short term**				
Consequence	**Reliance on unplanned outsourcing of services leading to increased costs**				
Impact per year					Assume unplanned outsourcing is equal to cost of outsourcing the service in Option 1 (£4m p.a.)
Probability					75%
Timescales					Years 2 - 11
Total Risk Value £'000	**Does Not Apply**	**Does Not Apply**	**Does Not Apply**	**Does Not Apply**	**29,740**
K6 - Workforce Risk: Recruitment and Retention (long term)					
Risk	**Unable to recruit sufficient staff to enable delivery of the model in the long term**				
Consequence	**Reliance on unplanned outsourcing of services leading to increased costs**				
Impact per year		Assume unplanned outsourcing is equal to cost of outsourcing the service in Option 1 (£4m p.a.)	Assume unplanned outsourcing is equal to cost of outsourcing the service in Option 1 (£4m p.a.)	Assume unplanned outsourcing is equal to cost of outsourcing the service in Option 1 (£4m p.a.)	Assume unplanned outsourcing is equal to cost of outsourcing the service in Option 1 (£4m p.a.)
Probability		2.5%	2.5%	2.5%	5%
Timescales		Years 12 - 62	Years 12 - 62	Years 12 - 62	Years 12 - 62
Total Risk Value £'000	**Does Not Apply**	**5,056**	**5,056**	**5,056**	**10,112**

Element	Option 0 - BAU	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
K7 - Outsourcing Risk: Increased Handover Costs					
Risk	**For the fully outsourced option, risk that costs for the handover of ISP owned building at end of the contract is understated**				
Consequence	**Increased handover payment at end of contract**				
Impact per year		25% increase on current assumed Handover Cost			
Probability		25%			
Timescales		Year 12			
Total Risk Value £'000	**Does Not Apply**	**15,364**	**Does Not Apply**	**Does Not Apply**	**Does Not Apply**
K8 – Outsourcing Risk: Building Provided by ISP Doesn't Meet HB Requirements					
Risk	**For the fully outsourced option, risk that handover of ISP owned building at end of the contract does not fully meet HB requirements due to less control at design stage**				
Consequence	**Increased lifecycle costs**				
Impact per year		Lifecycle Costs are doubled			
Probability		10%			
Timescales		Years 12 - 62			
Total Risk Value £'000	**Does Not Apply**	**9,870**	**Does Not Apply**	**Does Not Apply**	**Does Not Apply**

6.9 Economic appraisal

The Comprehensive Investment Appraisal (CIA) model has been populated with the assumptions outlined above to support the appraisal of overall value for money by producing a cost-benefit analysis of the shortlisted options.

The assumptions above have been incorporated into a discounted cash flow for each of the costs, benefits and risks are calculated over a 63-year appraisal period including Year 0 (base year) + 19 months construction/commissioning + 60 years estimated useful life.

- Year 0 is 2025/26
- Costs and benefits use real base year prices – all costs are expressed at 2025/26 prices in line with the baseline costs.

The following costs are excluded from the economic appraisal:

- Exchequer ***transfer*** payments, such as VAT
- General inflation
- Sunk costs
- Non-cash items such as depreciation and impairments
- A discount rate of 3.5% is applied to years 1-30, 3.0% from year 31 onwards.

The economic summary is provided in the table below and a copy of the CIA model is provided in Appendix 10.

Table 25 - Economic summary

Element	Option 0 - BAU	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
Capital expenditure including contingency (discounted)	0	-98,417	-137,538	-146,828	-146,828
Revenue expenditure (discounted)	0	-180,472	-145,534	-145,498	-129,422
Operational Risks	0	-59,101	-5,291	-9,971	-34,480
Risk-adjusted Present Cost	**0**	**-337,989**	**-288,363**	**-302,298**	**-310,729**
Cash releasing benefits (discounted)	0	0	0	0	0
Non-cash releasing benefits (discounted)	0	0	0	0	0
Societal Benefits (discounted)	0	327,217	327,217	327,217	327,217
Total Benefits	**0**	**327,217**	**327,217**	**327,217**	**327,217**
Discounted Net Present Social Value (NPSV)	**0**	**-10,772**	**38,855**	**24,920**	**16,488**
Incremental costs - total	0	-337,989	-288,363	-302,298	-310,729
Incremental benefits - total	0	327,217	327,217	327,217	327,217

Element	Option 0 - BAU	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
Risk-adjusted Incremental Net Present Social Value (NPSV)	**0**	**-10,772**	**38,855**	**24,920**	**16,488**
Benefit-cost ratio	**0.00**	**0.97**	**1.13**	**1.08**	**1.05**

Option 2, which entails a traditional capital build of Phase 1 of the LHP (the Community Diagnostics Hub portion), with an ISP providing the service provision equipment and delivering the service via a managed service contract for the first 10 years before the service becomes inhouse and run by the Health Boards, provides the best value for money of the options. This option would deliver an incremental Net Present Social Value (NPSV) of £38.9m when compared to the Business as Usual (BAU) position and a Benefit Cost Ratio (BCR) of 1.13. This means that £1.13 of incremental benefit is delivered for every £1.00 of incremental whole life cost, which suggests LHP will deliver value for money.

Option 2 offers the best value for money primarily due to it bringing the least operational risk when compared to the other options, while also providing all the same quantifiable benefits as the other options. This option also provides all the outlined non-monetisable benefits, including the ability to develop a robust, skilled and sustainable endoscopy workforce.

It should be noted that this is based on an initial assessment of benefits and risks with further work being required to fully quantify several of the benefits and risks of each option as the scheme progresses to Full Business Case (FBC) stage. Where benefits have been quantified, values have been estimated based on current assumptions as outlined in section 7.6 of this case. Given further work is required at FBC to validate and refine these assumptions, a relatively low confidence rating has been attached to the majority of these to ensure a prudent approach is taken to claiming benefits until a more detailed analysis can be undertaken. It is therefore reasonable to assume that at FBC stage, the BCR is likely to increase and further strengthen the value for money case.

Option 3, which involves a Traditional Capital Build for LHP Phase 1 with the specific service provision equipment being supplied by Welsh Government/Health Boards, while the diagnostics service is provided by an ISP through a managed service contract for the initial period, has the next best value for money of the options. It has a slightly lower BCR (1.08) and NPSV (£24.9m) largely because it provides the same benefits as Option 2 but has a higher initial capital outlay from the Health Boards having to provide the specific service provision equipment and having slightly higher level of risk attributed to it.

Option 4, which entails a Traditional Capital Build for LHP Phase 1 and the whole diagnostics service being provided by the Health Boards, offers the next best value for money, with a BCR of 1.05 and an NPSV of £16.5m. There are significant risks around this option including that there would be difficulty recruiting sufficient NHS diagnostics staff to deliver the service in the first 10 years, which could lead to a poorer service being provided, expensive temporary and locum staff having to be used, or poorer service occurring across the region, as staff in those areas are re-located to LHP. It should be noted that a key benefit of using a managed service contract for the initial period is to develop a diagnostic workforce capable of providing the service during that period, which would not be available in this option.

Option 1, which entails both the construction of Phase 1 of LHP and the diagnostics service being fully outsourced to an ISP, delivers the lowest BCR (0.97) and would result in a Net Present Cost of £10.8m. This is because there are significantly higher revenue impacts in this option; it is still expected that the Health Boards would have to purchase the LHP back from the ISP at the end of the managed service contract at, at least the Net Book Value and that there are significant risks attached to this option including finding an ISP that would be willing to design and construct the LHP which would lead to significant delays to the programme.

6.10 Sensitivity analysis

The results of the economic appraisal above have been subject to a sensitivity analysis to examine the impact of potential movements in capital and revenue costs.

The first part of this involves undertaking a switching values analysis to test the robustness of the ranking of options. This is applied to areas of material cash flows to identify the extent that costs and benefits of each of the alternative options must change for the BCR to reflect that of the highest-ranking option (excluding BAU). This analysis is outlined in the table below:

Table 26 - Sensitivity switching analysis (BCR)

	Option 1 - Fully outsourced managed service contract	**Option 3 -** Traditional capital build and equip + ISP deliver services via managed service contract	**Option 4 -** Traditional capital build and equip + NHS staffing and service provision
Increase in benefits to equal preferred option	17.2%	4.8%	7.8%
Decrease in capital costs to equal preferred option	-50.4%	-9.5%	-15.2%
Decrease in revenue costs to equal preferred option	-27.5%	-9.6%	-17.3%
Decrease in quantitative risks to equal preferred option	-84.0%	-139.8%	-64.9%
Decrease in total costs to equal preferred option	-14.7%	-4.6%	-7.2%

This demonstrates that in order to change the ranking of the options:

- Option 3 would need to improve its current benefits by 4.8% (£15.8m) or otherwise reduce capital costs by 9.5% or revenue costs by 9.6% (£13.9m) to rank equal to Option 2.
- Option 4 would need to improve its current benefits by 7.8% (£25.4m) or otherwise reduce capital costs by 15.1%, revenue costs by 17.3% or quantified risk by 64.9% (£22.4m) to rank equal to Option 2.
- Option 1 would need to improve its current benefits by 17.2% (£56.3m) or otherwise reduce capital costs by 50.4%, revenue costs by 27.5% or quantified risk by 84.0% (£49.6m) to rank equal to Option 2.

This suggests that Options 3's rankings are relatively sensitive to benefit or cost assumptions, however noting that this option and the preferred option have the same benefits and relatively similar cost assumptions it is likely that any change in benefits and costs would be similar in both Option 3 and the preferred option. As such it is unlikely that this option could overtake Option 2 as the preferred option.

This suggests that Options 1 and 4's rankings are not particularly sensitive to benefit or cost assumptions and so it is unlikely that these options would overtake Option 2 as the preferred option.

Additionally, to the switching analysis, alternative scenarios have been calculated to consider how the value for money of the options may be affected by future uncertainty as outlined in the table below.

Table 27 - Sensitivity analysis scenarios

Scenario	**Option 2 (PWF) -** Traditional capital build + ISP equip and deliver services via managed service contract	**Option 1 -** Fully outsourced managed service contract	**Option 3 -** Traditional capital build and equip + ISP deliver services via managed service contract	**Option 4 -** Traditional capital build and equip + NHS staffing and service provision
Original Results (BCR)	**1.13**	**0.97**	**1.08**	**1.05**
1.Initial Capital costs increase by 20%	1.08	0.97	1.03	1.00
2. Revenue costs in Options 2 and 3 are 10% higher due to the tariff discount for land and building in options 2 and 3 not being as large as estimated	1.08	0.92	1.03	1.01
3. Building Buy Back value in Option 1 is 20% lower than expected	1.13	0.99	1.08	1.05
4a. Improved patient outcomes (cancer related) as a result of shorter diagnostics waiting times confidence rating decreased from 25% to 12.5%	0.92	0.78	0.87	0.85
4b Improved patient outcomes (cancer related) as a result of shorter diagnostics waiting times confidence rating increased from 25% to 50%	1.57	1.34	1.50	1.46
5a. Improved patient outcomes (non-cancer related) as a result of shorter diagnostics waiting times confidence rating decreased from 25% to 12.5%	0.80	0.68	0.76	0.74
5b Improved patient outcomes (non-cancer related) as a result of shorter diagnostics waiting times confidence rating increased from 25% to 50%	1.81	1.55	1.73	1.68
6. Costed Risks are overstated by 20%	1.14	1.00	1.09	1.08

In summary:

- **Scenario 1**: Even if initial capital costs were to increase by 20% (c.£14m excluding VAT), this would have minimal impact on the BCR of all options, and the preferred option would still deliver a positive NPSV.
- **Scenario 2**: A 10% increase in revenue costs in Options 2 and 3 (c. £538-747k p.a. increase in the preferred option) would have minimal impact on the BCR of Options 2 and 3, and the preferred option would still deliver a positive NPSV.
- **Scenario 3**: if the Building Buy Back value in Option 1 is 20% lower than expected Option 1's BCR would increase however it would not overtake Option 2 as the preferred option.
- **Scenario 4**: The benefit associated with improved patient outcomes as a result of reduced Diagnostics waiting times for patients with a suspected cancer appears to have a significant impact on the value for money indicators for all options. For instance, if the confidence rating was reduced from 25% to 12.5% this would reduce the BCR for the preferred option from 1.13 to 0.92, while increasing it to 50% would improve the BCR to 1.57. While this suggests value for money is relatively sensitive to changes in the confidence rating applied to this benefit, it should be noted that there is still some work to be done at FBC stage to quantify more of the benefits, as well as firming up the level of certainty in those already quantified, which would likely mitigate this.
- **Scenario 5**: The benefit associated with improved patient outcomes as a result of reduced Diagnostics waiting times for patients with non-cancer related health issues also appear to have a significant impact on the value for money indicators for all options. For instance, if the confidence rating was reduced from 25% to 12.5% this would reduce the BCR for the preferred option from 1.13 to 0.80, while increasing it to 50% would improve the BCR to 1.81. While this suggests value for money is relatively sensitive to changes in the confidence rating applied to this benefit, it should be noted that there is still some work to be done at FBC stage to quantify more of the benefits, as well as firming up the level of certainty in those already quantified, which would likely mitigate this.
- **Scenario 6**: if the costed risks in each of the options was overstated by 20%, this would have minimal impact on each of the options BCRs and it would have no effect on the rankings.

The results of the scenario analysis show that the BCR is relatively sensitive to some changes in assumptions, specifically the confidence rating applied to patient outcomes associated with reducing diagnostic waiting times. However, it is believed that as the project progresses to FBC and assumptions can be firmed up, it will be possible to monetise further benefits and increase the confidence rating applied to those already quantified. This would likely increase the BCR overall.

6.11 Preferred option

The results of the economic appraisal demonstrate that the preferred way forward offers value for public money.

Option 2, which utilises a traditional capital for the build of phase 1 of the LHP (the Community Diagnostics Hub portion), with an ISP providing the service provision equipment and delivering the service via a managed service contract for the first 10 years before the service becomes inhouse and run by the Health Boards, will require capital investment of £109.1m and ongoing revenue costs of £7.5m (excluding depreciation) for the initial 10 year period of the managed services contract, reducing to £5.4m after the end of the contract. Based on estimated costs and benefits, it is anticipated that this option will deliver an incremental Net Present Social Value (NPSV) of £38.9m and a Benefit Cost Ratio (BCR) of 1.13.

This represents £1.13 of incremental benefit delivered for every £1.00 of incremental whole life cost, because of the quantifiable benefits that it has been possible to state in monetary values at this point in time, including:

- **Improved patient outcomes from earlier diagnosis:** Delivery of the CDC will address CTMUHB Diagnostic Imaging and regional Endoscopy capacity shortfalls and ensure future demand can be met. This will have a direct impact on waiting times for patients and support the cancer pathway by enabling earlier diagnosis, more targeted interventions and improved monitoring. This will lead directly to delivering better patient outcomes, specifically contributing to improved cancer survival rates.
- **Improved patient outcomes from earlier diagnosis (non-cancer related)**: Delivery of a significant increase in additional Endoscopy capacity should lead to earlier and increased diagnosis for patients with health issues other than cancer such as hypertension, which will lead to better patient outcomes and help contribute to reduced mortality related to those health issues.

In addition to this, there are other quantifiable benefits which it has not yet been possible to state in monetary values given the information that is available at this time. These will be explored further at FBC-stage and, it is expected, will further strengthen the BCR. These include:

- **Release of elective diagnostic capacity at Acute sites, which can be used for urgent and emergency care patients/pathways:** The capacity provided at LHP for more elective diagnostic tests will free up Acute sites to use their diagnostic capacity for non-elective scans/tests, which reduce delays for urgent and emergency patients.
- **Improved predictability and confidence in booking scans and tests:** The centralised elective centre with co-located services provides a 'one-stop' shop clinic with greater predictability of care which in turn means that scans and tests can be booked with more confidence leading to improved utilisation of the service.
- **Impact of a more sustainable estate:** The delivery of appropriately designed and compliant facilities provides opportunities to contribute to CTMUHB's environmentally sustainable goals and national strategies around decarbonisation and optimising energy efficiency. The transformed model of care with its standardised pathway is likely to make it easier to implement and maintain sustainability programmes that CTMUHB has instituted in other areas, such as reducing waste and single use products.

LHP will also deliver various non-financial benefits which while they cannot be quantified in monetary terms are equally important to the delivery of local, regional and national policy. These include:

- **Additional Imaging and Endoscopy capacity leading to reduced waiting times:** The additional capacity at LHP will allow the Health Boards to meet the NHS Wales target that no patient is waiting more than 8 weeks for imaging or endoscopy tests.
- **Help to meet 'Straight to Test Guidance':** The additional capacity provided at LHP will assist with meeting 'Straight to Test Guidance', allowing an increase in the number of direct referrals from GPs to radiology. It will also allow for improved regional sustainability and provide contingency for other sites across the region.
- **Increased number of and improved clinical pathways:** Due to LHP being a centralised elective centre and a "one-stop" clinic, it will lend itself to developing and delivering more and improved clinical pathways. These pathways and improved ways of working could be used as an exemplar and then also be rolled out across the region.
- **Reduced health inequalities:** Reduction in waiting times and ease of access supports equality of access.

- **Community Benefits:** The contractor has agreed to implementing several community benefits, including hiring local, providing volunteering and donations to local organisations, investing in people learning and using Welsh and investing in the local supply chain.
- **Improved patient experience:** As well as reduced waiting times patient experience is enhanced by the modern fit for purpose facilities and the ease of access the location of LHP offers, with its good road links and parking. Having a centralised elective centre with co-located services provides the convenience of a ***one-stop shop*** clinic with greater predictability of care.
- **Increased staff satisfaction:** The improved training pathway and increased training opportunities, along with the modern fit for purpose facilities and a consolidated service model that enables more effective ways of working, contributes to staff satisfaction and creates an attractive place to work which will support recruitment and retention of highly trained health professionals in the long term.
- **Develop a skilled endoscopy workforce:** Delivery of the Skills Academy in partnership with HEIW will provide significant opportunities to increase the number of training places available in the region and help to build a skilled and sustainable endoscopy workforce.
- **Increased compliance:** The dedicated CDC will ensure that the Health Boards have capacity across the region to ensure alignment with GiRFT principles and continue to achieve JAG accreditation. Modern fit for purpose facilities that are compliant with WHBNs and HTNs, achieve BREEAM rating of Excellent.
- **Future proofing:** The site also provides a level of future proofing by providing expansion space that offers opportunities for other future developments.
- **Opportunities for future transformation:** The additional capacity offered by LHP provides opportunities to transform and reconfigure core local services and deliver things differently in the future. Further to this the robust and in-depth data/reporting the service at LHP will provide to the Health Boards will greatly inform future decisions. The successful delivery of a regional centre will also provide proof of concept as the basis for the development of any future regional pathways and will have a positive reputational effect.

The results of the options appraisal (excluding BAU) are presented in the table below.

Table 28 - Results of options appraisal

Element	**Option 1 -** Fully outsourced managed service contract	**Option 2 (PWF) -** Traditional capital build + ISP equip and deliver services via managed service contract	**Option 3 -** Traditional capital build and equip + ISP deliver services via managed service contract	**Option 4 -** Traditional capital build and equip + NHS staffing and service provision
Initial capital investment	£0m	£109.1m	£119.7m	£119.7m
Incremental NPSV	**-£10.8m**	**£39.9m**	**£24.9m**	**£16.5m**
Benefit Cost Ratio	**0.97**	**1.13**	**1.08**	**1.05**
Key benefits	As per benefits outlined above for the Preferred Option	As per benefits outlined above for the Preferred Option	As per benefits outlined above for the Preferred Option	As per benefits outlined above for the Preferred Option
Key risks	• Unable to secure a service provider who would be willing to provide the service • Unable to secure revenue funding • Implementation is delayed due to increased procurement timescales	• Significant initial capital outlay • Unable to secure revenue funding	• Significant initial capital outlay • Unable to secure revenue funding • Implementation is delayed due to increased procurement timescales	• Significant initial capital outlay • Unable to secure revenue funding • Implementation is delayed due to increased procurement timescales • Unable to recruit sufficient staff to enable

Element	**Option 1 -** Fully outsourced managed service contract	**Option 2 (PWF) -** Traditional capital build + ISP equip and deliver services via managed service contract	**Option 3 -** Traditional capital build and equip + ISP deliver services via managed service contract	**Option 4 -** Traditional capital build and equip + NHS staffing and service provision
	• Significant risks around handover of the building at the end of the managed service contract period, including higher than expected handover costs and that the building would not fully meet the Health Boards requirements.			delivery of the model in the short term

It should be noted that this assessment is based on an initial assessment of benefits and risks and further work is required to quantify these more fully. As outlined above, it is anticipated that this is likely to further strengthen the BCR and value for money case as the scheme progresses to FBC stage.

Commercial Case

7 Procurement strategy

7.1 Introduction

This section of the business case outlines the procurement strategy and proposed deal to deliver the preferred option to develop a community diagnostic hub for CTMUHB, co-located with a regional endoscopy centre on the Llantrisant Health Park site, as discussed in the economic case. The preferred delivery model would be to undertake the build and fit out of the site using NHS capital funds and deliver the services through a contract with a commercial service partner who would also equip the facility.

The former British Airways Avionics Engineering (BAAE) site was acquired by CTMUHB in February 2023. The Llantrisant Health Park site will comprise a Community Diagnostics Hub, Orthopaedic Surgical Hub with associated ward accommodation, and other regional services, which may include Day Surgery. The Community Diagnostics Hub will be delivered as the first phase of a multi-phase development.

The following section sets out the commercial arrangements for the capital LHP site, including procurement and delivery of the design and build and fit out, with the procurement strategy for the independent delivery partner shown in section 7.3.

7.2 Procurement of the Capital Build and Fit Out

Work on the design of the CDH commenced shortly after the site purchase in the autumn 2023 and progressed via the appointed design team lead by Strides Treglowan Architects. The design team progressed through the RIBA design stages from masterplanning to completion of RIBA 2 in December 2024 culminating in the approval to commence demolition works and RIBA 3 design works in December 2024.

Alongside the completion of the RIBA 2 works, work had commenced on the appointed of separate contractors for the demolitions and the main build programmes and each will be set out as below:

7.2.1 Demolition Contractor procurement

A detailed procurement tender was undertaken by CTMUHB procurement and NWSSP using the Crown Commercial Services Framework, Construction Works and Associated Services Lot 10 Demolition framework.

The procurement was prepared and completed by CTMUHB, the appointed design team and NWSSP procurement services. The procurement process was undertaken for a new contract, whereby an Expression of Interest was issued to 13 national demolition providers on 30 October 2024 and providers had until 31 October 2024 to respond. Following the deadline, only five providers responded to the Expression of Interest.

A Mini competition was undertaken, utilising *RM6088 Construction Works and Associated Services Framework lot 10 Demolition*, and was published via e-Tender Bravo portal, in which certain selection criteria was applied at the qualification, technical and commercial evaluation stages.

Tenders were published on 1 November with the deadline for submission on 25 November. At the end of the tender period, five submissions were received, however after review, two suppliers failed to meet the minimum criteria, leaving three for scoring. Detail of the scoring approach is included in the tender analysis submitted as part of the estates annex.

A preferred supplier was identified and appointed in January 2025 following WG approval of funding for demolition works to proceed.

The contract has commenced and works began on site on 14 April 2025. This contract was originally programmed to conclude by 22 August 2025, however, there has been a delay of around three weeks, and the works are now expected to complete by 20 September, when the contractor will leave site.

7.2.2 Main Contractor procurement

The main contractor tender process completed in November 2024. The tender was issued via the Crown Commercial Services (CCS) framework. The Welsh NHS run Building for Wales (BfW) framework was not selected due to:

- Delays in the implementation of the new framework after the previous one ended in April 2024
- Delays associated with securing the funding information required to commence the tender
- Inclusion of high levels of modular development in the design, with no modular supplier on BfW this would not have provided value for money.

As a result, a framework was selected that enabled the Programme to test the appetite and ability of both modular and other modern methods of construction (MMC) contractors to respond and offer the most advantageous infrastructure solution to the programme. A two-stage design and build contract solution was selected with a fixed price for the professional services and a target cost model for the construction phase (similar to the contractual arrangements under BfW).

An expression of interest was issued in October 2024 and seven companies opted in to show an interest. The tender was published on 13 November 2024 and after two extensions, closed on 31 January 2025.

The process has been managed by Mott McDonald, acting as primary PM for tender and procurement exercise and at all stages support has been provided by NWSSP procurement services.

The tender period closed on 31 January 2025 with three responses received. There were some clarifications required from tendering parties, the detail of which is available if required. Legal advice was sought regarding the contractual terms and conditions.

By the end of the process, only one contractor confirmed full acceptance of the proposed terms and conditions for both design and build contracts. In addition, the same contractor offered the best overall score in the combined qualitative and quantitative analysis. This information can be found in the tender analysis report contained in the estates annex to the business case.

Following completion of the tender scoring, the outcome was presented to NWSSP-SES and a paper prepared for WG approval for CTMUHB to appoint MTX, the preferred contractor. This approval was granted by letter on 14 March and, following the mandatory 10 day standstill period, MTX were appointed as the successful contractor on 31 March 2025, under an NEC professional services contract, to deliver the design up to completion of RIBA 4 and development of target cost.

Once FBC approval is received, CTMUHB will enter into an ECC contract with MTX to deliver the phased construction solution. This is expected to be structured to support sectional completion in line with the LHP phased construction programme.

Tendering parties provided costs up to RIBA 4 completion, as per standard NEC professional services contract (PSC). This will enable generation of completed design, securing of planning and SAB approvals, with fully tendered build costs. As a design and build arrangement, and to proceed to construction, an ECC contract will be required to be entered into on FBC approval.

CTMUHB requested WG approval to enter into the full PSC contract, which would take the scheme up to RIBA 4, at a contractor design fee cost of £3.935m. This cost excludes VAT and the additional health board fees associated with both RIBA 3 and 4. Full costs are included in the finance section of this case.

It should be noted that the cost tendered by the contractor was based on a single business case process and start-on-site of a phased construction completion programme. The recent decision and instruction to split this work into phases, each with its own business case and development programme, has subsequently elongated the programme and increased the level of costs and fees incurred. A longer design period will mean further costs for all time-based consultants. Additional design works will also be required to ensure that Phase 1 can be fully operational as a standalone building for a longer period. In addition, the ability to create linked buildings whilst maintaining the operational status of the CDH has also had to be considered and resulted in some redesign of the area that will immediately adjoin Phase 2.

One of the key areas of impact has been around the mechanical and electrical engineering and medical gases works, where short term solutions had been proposed to support a phased opening whilst construction of other phases, including the permanent engineering infrastructure, was completed. With the risk of a longer period of opening without this infrastructure in place, the timing and location of much of the supporting infrastructure has had to be reconsidered and alternative areas included. This has also brought much of this forward in the programme and means it is included in Phase 1.

Work with the construction partner has confirmed the level of fees to support the Phase 1 contract however the design fees for Phases 2 and 3 are under review and being developed at the time of writing this business case. This information will be included in the phase 1 FBC and the Phase 2 OBC.

In December funding was approved for the RIBA 3 design stage of £3.5m which included stages 3A and 3B, 3B undertaken by MTX. RIBA 3A was completed by the end of March 2025, with RIBA 3B completed by the main contractor by 30 June 2025.

As per the tender return, the total MTX fees only for the design stage are £3.935m based on a fixed price submission. The total Phase 1 fees have now been agreed and sit within this sum. Phase 2 fees are currently being agreed, and it is likely that these will exceed this original tendered sum and will require an uplift.

Table 29 - Breakdown of original tendered fees

Cost element	RIBA 3 £000	RIBA 4 £000	Total £000
Design fees	377	2,632	3,009
Management services	-	495	495
Surveys	-	207	207
Overhead and profit @ 6%	23	200	223
Total	**400**	**3,535**	**3,935**

As mentioned above this covered the total programme costs. Whilst the RIBA 3 costs have not changed, from those committed above, the sums for phase 1 RIBA 4 have changed.

Phase 1 RIBA 4 costs are £2.573m, however this represents main contractor design fees only. The total RIBA 4 cost up to approval of the FBC and contractor start on site are as set out in Table 30 Table 31 below, to date £2.828m funding has been received from WG, approved on 12 August. Therefore, the balance sought to complete RIBA 4 and proceed to works on site will be £2.177m

Table 30 - Requested fees to complete RIBA 4 up to start on site

Fee description	Forecast cost £000
Health Board Fees	1,507
MTX Fees	2,573
Non works costs	341
Planning Fees	430
Sub total	**4,851**
VAT (less recoverable)	154
Total cost	**5,005**
Funding Received to OBC	-2,828
Balance of funding required	**2,177**

Should a decision be made not to complete RIBA 4 following the outcome of this business case then there is a risk of a contractor claim against the Health Board under the PSC contract. Whilst any payment is likely to be negotiated, it is probable that a sum amounting to any actual costs rightfully instructed and incurred will be paid, alongside a claim for loss of profit on all phases and likely to be around two months of committed / contracted cost.

As a worst-case scenario, this could amount to a liability of approximately, £1.3m however it is likely to be significantly lower after negotiation.

7.3 Independent Service Provider (ISP) procurement

CTMUHB, acting on behalf of the three Health Boards in South East Wales is currently undertaking a procurement exercise to appoint a prime contractor to act as a design partner and contributor to the pathway redesign currently being scoped out for diagnostic services to provide one imaging CDH with the option to flex to one further CDH over the course of the contract. In addition, the CDH will also have at the same location, an ISP staffed Endoscopy Suite comprising of up to four rooms co-located with an NHS staffed two room Endoscopy Training Academy. The endoscopy suite requirements will be designed and fitted out to meet JAG accreditation standards.

There will be a co-located training academy which will include an endoscopy theatre. It is expected that the fitting out of the academy training rooms, and delivery of activity will be facilitated by NHS organisations through collaborative work with Health Education and Improvement Wales.

The Regional Radiology Project Board and the Regional Diagnostics Programme Board endorsed the use of competitive dialogue to test the market potential to support the development of a regional diagnostic centre and associated community diagnostic hubs, one of which will be on the LHP site. The competitive dialogue procedure is flexible and allows the Procurement Evaluation team to discuss proposed solutions with bidders to understand advantages and disadvantages.

The recommended option is to develop a regional endoscopy centre through a traditional NHS capital build proposal and to seek the equipment and delivery of the centre activity through contract with a commercial partner.

To drive this strategy, further competitive dialogue will need to be completed to understand financial implications and other non-financial risks. The current procurement programme leads to the appointment of the ISP by the end of October 2025.

The successful provider will provide a range of new clinical and non–clinical equipment items, including furniture as required for the commissioned services. Equipment must be new and installed at the start of the contract. The overall requirement would be expected to provide economies of scale linked to staff resources, training and cross cover; logistics associated with consumables, equipment, maintenance, corporate and management overheads.

The proposed contract between CTMUHB and the ISP is for an initial period of seven years from the operational commencement date with an option to extend for up to an additional three years (in 12 month tranches).

As stated above, MTX, the main contractor, has been appointed to undertake the modular construction of the whole site and the CDH shell for the ISP to equip, commission and operate.

7.4 Health Board contracting arrangements

CTMUHB will enter into the ISP contract with the successful bidder. The proposed contract mechanism with the ISP partner will be a cost per case arrangement with a base minimum level of expected activity creating a floor financial value for each modality of service. Any activity over and above this floor will be charged on an agreed marginal cost per case using agreed activity currencies.

Initial volumes indicate a potential for surplus capacity at the site that the commercial service provider could utilise for private patient access, all non NHS activity undertaken at the site will attract an enhanced rate for the health boards' contract with the supplier for the NHS activity.

During the next few months arrangements with regional partners will be confirmed so that upon entering into contract with the ISP there is a confirmed and signed agreement in place with all regional partners for contracting and recompense. This will be further detailed at FBC stage.

7.5 Workforce Plan for CDH Delivery via ISP/MSC e plans

7.5.1 Background

There is a well-documented shortage in the diagnostic workforce across Wales, particularly in radiology and endoscopy. This has created a significant barrier to timely diagnostics and service delivery, impacting patient outcomes and system flow across south Wales.

To address this, the Community Diagnostic Hub (CDH) model will be delivered in the medium term through an Independent Sector Provider (ISP) under a Managed Service Contract (MSC). The ISP will operate independently with its own commercial and operational model but must align with NHS Employers standards and the strategic workforce objectives of Cwm Taf Morgannwg UHB (CTM) and the wider South East Wales region.

The MSC is expected to be a seven-year contract, with the option of three one-year extensions (7+1+1+1), subject to performance and strategic review. This provides a stable platform for service delivery while allowing flexibility for future transition planning addressing the workforce pipelines shortages that will be essential to transition back in house.

Whilst the new ISP provider must define its own commercial structure to have its own identity and flexibility to function, through this it must also provide robust assurance to all stakeholders. They must provide a safe and effective workforce that delivers a safe and high-quality service to the users of the facility.

7.5.2 Assurance

To ensure the ISP delivers a safe, effective, and sustainable workforce model, a robust assurance framework will be embedded in the tender and contract documentation.

Workforce KPIs

The contract will include a suite of workforce-related Key Performance Indicators (KPIs), such as:

- Staffing levels and skill mix appropriate to meet service demand demonstrating efficiency
- Compliance with professional registration and revalidation
- Completion of Statutory and Mandatory Training (StatMan Framework)
- Sickness absence, turnover, and retention rates
- Use of agency or temporary staff, ratio to substantive
- Evidence of qualifications, DBS checks, and safe recruitment practices
- Percentage of workforce recruited from within South East Wales, the wider UK, and internationally.

Recruitment standards

All recruitment must align with NHS Employers governance and standards. The ISP will be required to demonstrate adherence to safe recruitment practices, including verification of qualifications, right to work checks, enhanced DBS clearance, and reference checks.

These requirements will be explicitly stated in the tender and contract documentation aligned to the parameters of the framework compliance.

Workforce impact mitigation

While the ISP cannot be contractually prevented from recruiting CTMUHB staff, the contract will include mechanisms to monitor and limit the impact on the existing South East Wales workforce. KPIs will track recruitment sources and workforce movement to ensure the ISP does not destabilise local services. The ISP will be expected to work collaboratively with CTMUHB and regional partners to support workforce sustainability.

Partnership and governance

CTMUHB will ensure senior workforce representation on the tender evaluation panel. Workforce and clinical experts will review the provider's submitted workforce plan to ensure appropriate skill mix and competencies, suitability for CDH service delivery, and alignment with patient safety and training standards.

Providers will be expected to demonstrate experience of collaborative working with NHS facilities in England or similar settings, with a proven record of partnership and workforce stability.

There will be monitoring of the service delivery and workforce through regular contract meetings with the ISP

7.5.3 Transition back in-house

The long-term ambition is to transition diagnostic service delivery back into CTM, ensuring integration, sustainability, and alignment with NHS values.

Transition planning

The timing of the transition will be defined collaboratively with the appointed provider during the tender and contract agreement stage, recognising the dialogue-based nature of the contract. CTMUHB will begin scoping the transition plan during the contract period, depending on service maturity and workforce readiness. The addition of the Skills academy will support the development of an increased work force to provide a greater number of staff trained with skills to work within an endoscopy environment. This will form a key component of the plan to bring the CDH endoscopy service back into the NHS

The transition plan will include:

- A training and development programme to support internal workforce growth
- Exploration of dual running costs to support over-recruitment and phased handover
- Scope and develop a transition plan that will comply with the legal regulation (TUPE) to move workforce from the ISP to CTMUHB contract of employment
- Engagement with HEIW (for endoscopy) and the Radiology Academy to support workforce development and succession planning.

Workforce Development

CTMUHB will explore opportunities to develop new roles and increase skill mix, including:

- Clinical support workers
- Assistant practitioners
- Advanced radiographers.

These roles will be developed in partnership with the ISP, drawing on their experience and models used elsewhere throughout Wales and England. The transition plan will also include a skills gap analysis and a future workforce model to ensure readiness for in-house delivery model with a clear plan around the transition timeline.

Education and training

CTMUHBand regional partners will work to provide better access to education and training, supporting:

- Upskilling of existing staff
- Development of new career pathways
- Attraction and retention of local talent.

The ISP will be expected to contribute to this agenda by sharing best practice, supporting placements, and participating in joint workforce planning.

Monitoring and evaluation

Regular review points will be built into the MSC to assess readiness for transition. Workforce impact assessments will inform decision-making. Ongoing stakeholder engagement will ensure transparency and shared ownership of the transition process.

7.5.4 TUPE arrangements and/or transfer of staff

It is not anticipated that TUPE will apply to any existing NHS staff in the establishment of the service agreement as there will be no change to existing capacity at the Health Board.

Following the end of the Contract term there may be TUPE implications for staff employed by the Commercial Service Provider in the continuation of the services either by NHS providers or by any subsequent Commercial Service Provider Partner.

It is anticipated that there will be no TUPE arrangements required in relation to the wider site development as staff would not be required to transfer out of their existing organisation. This will be reviewed at FBC.

7.5.5 Adapted-risk service model

Detailed workforce implications will continue to be developed as part of revenue assessments. This service model is anticipated to lead to some workforce efficiencies as there will be improved integration within teams and support systems.

7.6 Associated disposals

There are no known disposals associated with this development, which would generate income for the three Health Boards.

7.7 Design and compliance with mandatory standards

7.7.1 NHS Net Zero compliance

In October 2020 the NHS published the ***Delivering a Net Zero National Health Service*** in response to the health emergency that climate change will bring. More intense storms and floods, more frequent heat waves and the spread of infectious diseases resulting from climate change threaten to undermine years of health gains.

Two clear and feasible targets emerge for the NHS net zero commitment, based on the scale of the challenge posed by climate change, current knowledge, and the interventions and assumptions that underpin this analysis:

- For the emissions the NHS controls directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;
- For the emissions that can be influenced (the NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

NHS Net Zero Building Standard

The NHS Net Zero Building Standard, published in February 2023, provides technical guidance to support the development of sustainable, resilient, and energy efficient buildings that meet the needs of patients now and in the future. 10% plus of the carbon emissions associated with operating the NHS estates are as a result of energy usage (operational carbon) alongside embodied carbon. The standard is a critical element in ensuring that the design, and construction of new NHS buildings and the inevitable refurbishment / repurposing of the existing estate, supports the “Delivering Net Zero” commitment to a zero-carbon estate by 2040.

The proposed LHP development design process will follow the guidance of the standard through RIBA stages 1-4.

The construction process for LHP will follow the guidance of the standard through RIBA stages 5-7. To facilitate this as required a Net Zero Carbon (NZC) Coordinator will be appointed who will be responsible for managing the process as well as being an advocate for Zero Carbon within the design team.

7.7.2 Modern Methods of Construction

NHS Wales and NHS Improvement with the Department of Health and Social Care, are working on progressing the approaches used to increase the use of Modern Methods of Construction (MMC) on all business cases requiring central NHS sign off. As part of this, an interim draft guidance has been developed for inclusion in the NHS Capital Business Case Fundamental Criteria Checklist.

Early consideration of the use of off-site manufacture, allows the process to be streamlined through the design and construction process, maximising the benefits this approach can bring. Agreement to an early BIM Execution Plan and sharing information in a project specific Common Data Environment (CDE) allows all parties to input in an integrated design, manufacturing, and assembly process.

LHP will be constructed using MMC and be entirely modular.

7.7.3 BREEAM

The Building Research Establishment Environmental Assessment Method (BREEAM) is the leading and most widely used environmental assessment method for buildings and communities. It sets the standard for best practice in sustainable design and has become the de facto measure used to describe a building's environmental performance.

As of 1 July 2008, all developments of new healthcare buildings in the UK seeking OBC approval must commit to achieving an EXCELLENT rating (assessed against BREEAM New Construction) and all refurbishments (assessed against BREEAM Non-Domestic refurbishment and fit-out) to commit to a VERY GOOD rating. Any project with a capital value exceeding the £2m threshold must include a BREEAM assessment.

BREEAM provides clients, developers, designers and others with:

- Market recognition for low environmental impact buildings
- Assurance that best environmental practice is incorporated into a building development
- Inspiration to find innovative solutions that minimise the environmental impact
- A benchmark that is higher than regulation
- A tool to help reduce running costs, improve working and living environments
- A standard that demonstrates progress towards corporate and organisational environmental objectives.

BREEAM addresses wide ranging environmental and sustainability issues and enables developers and designers to prove the environmental credentials of their buildings to planners and clients and:

- Uses a straightforward scoring system that is transparent, easy to understand and supported by evidence-based research
- Has a positive influence on the design, construction and management of buildings
- Sets and maintains a robust technical standard with rigorous quality assurance and certification.

BREEAM is a compulsory requirement for projects of this scale in Wales, as such work towards accreditation has been ongoing since RIBA Stage 1. The Design Stage Tracker set out the target ambition for the project to achieve BREEAM ‘Excellent’. Moving forward, workshops are to be set up for RIBA 3B stage, ensuring that design adaptions do not compromise the project trajectory.

7.7.4 Infection control

The proposed development will be designed and configured in compliance with HBN and HTM guidance to provide clean, well-designed environments within which clinical services and procedures can be carried out safely. Infection prevention and control measures will be designed into the new building through zoning, with appropriate clinical adjacencies to facilitate clean to dirty flows and the provision of good access for cleaning and maintenance to take place.

As planned for the design development at OBC stage, the clinical leads will be fully engaged to ensure the needs of users are understood and clearly articulated in the design brief. Health Board Infection Prevention and Control Teams will also be further engaged by the Project Team and Design Team to inform the detailed designs.

7.7.5 Sustainability

Efficient building services design can have a positive impact on future climate scenarios by reducing energy consumption and greenhouse gas emissions associated with buildings. Climate change is primarily driven by the release of greenhouse gases such as carbon dioxide, methane, and nitrous oxide into the atmosphere, and buildings account for a significant portion of these emissions.

When designing LHP, the aim will be to ensure that the building will operate as efficiently and sustainably as possible.

See Appendix 7; RIBA 3a report for further information on the design details.

7.8 VAT recovery

A VAT Advisor has not yet been engaged for OBC stage, but the Cost Forms allow for VAT recovery on fees and a nominal amount (5%) on the main build. Once into FBC Stage, engagement with the VAT Advisor will be sought.

7.9 Interface

The LHP finance representative has confirmed there is no interface between any NHS LIFT, PFI, PF2 or other PPP and there are no joint venture agreements/contracts already in place and therefore there are practical or contractual issues in the light of HM Government changes to the use of PFI in its various forms.

7.10 Summary and conclusion

Following a robust tender process, MTX have been appointed as the preferred contractor offering the most commercially advantageous tender, following both qualitative and financial appraisal.

Welsh Government approval for the balance of RIBA 4 cost of £2.177m which will fund the programme to complete RIBA 4 stage and through FBC approval and start on site is being sought as part of this business case.

Financial Case

8 Financial appraisal

8.1 Introduction

The purpose of the Financial Case is to outline the financial implications of the preferred option and assess affordability. As such it sets out the capital requirements and revenue consequences, along with underpinning assumptions, of the proposed scheme. It outlines anticipated funding arrangements and the impact on the overall financial statements.

As outlined in the Economic Case the preferred option involves an NHS funded capital build while an independent sector provider (ISP) provides and manages the necessary equipment and delivers MRI, CT, non-obstetric ultrasound (NOUS), and Endoscopy services.

8.2 Capital costs and funding

8.2.1 Capital costs

Delivery of the preferred option requires capital investment of £109.1m in total, including expenditure incurred to date. This is based on capital requirements prepared by the Health Board's Cost Advisors, Mott Macdonald using the following assumptions:

- Agreed Schedules of Accommodation and RIBA 3b design. Agreed scope of Phase 1 to cover the build of the CDH plus additional site wide infrastructure to facilitate later phases
- Proposed start on site 26 February 2026 and proposed works completion date end of July 2027. At completion the site will be handed over to the ISP for equipping and commissioning which is estimated to last 3-4 months
- Works costs calculated using benchmarked rates suitable for South Wales (including Healthcare Premises Cost Guide) @ BCIS TPI updated 20/08/2025.
- Allowances for fees, equipment costs, planning contingency have been applied as appropriate.
- No allowance for optimism bias has been applied given the degree of certainty at this stage in terms of maturity of design, knowledge of the site, and publicly declared political support for the development. It is therefore superseded by the Costed Risk Register figure.
- VAT advisor advice will be sought on VAT recovery options before FBC. Currently all fees are forecast to be VAT recoverable.

The resulting capital costs estimates are summarised in the table below and a copy of the detailed capital cost forms are provided in Appendix 8.

Table 31 - Capital costs

Element	Net £'000	VAT £'000	Total £'000
Works costs	58,058	11,611	69,669
Fees	14,463	2,892	17,355
Non-works costs	10,362	2,072	12,435
Equipment costs	2,628	526	3,145
Quantified risk contingency	10,583	2,116	12,699
Subtotal	**96,094**	**19,218**	**115,312**
Less: recoverable VAT	-	-5,323	-5,323
Total capital costs	**96,094**	**13,895**	**109,989**

The capital cost schedule includes costs for the provision of the CDH alongside a range of site wide infrastructure works to support the later phases of development. This is the most efficient way to deliver these services as it avoids having to dig up areas more than once. It also offers efficiencies in only requiring machinery and certain skills for a concentrated period of time in one phase therefore further reducing the risk of duplication in a phased approach.

The scope of sitewide works is detailed in the estates annex to this business case and has been shared with NWSSP-SES for their consideration. The inclusion of this element of the infrastructure does therefore mean that the capital costs appear above benchmarking if just measured across the 9,500m2 building footprint for Phase 1.

8.2.2 Funding requirements

Funding of £18.1m had been received to date from WG for:

- Site purchase - £8.0m
- RIBA 2 fees - £3.1m
- RIBA 3 fees - £3.5m
- Demolition - £0.7m
- RIBA 4 fees - £2.8m.

This includes funding of £2.828m which has been approved in August 2025 to support the phase 1 OBC redesign and the commencement of RIBA 4 works to support the FBC being completed for November Boards. Further funding of £91.9m is therefore requested from Welsh Government.

Table 32 - Capital cashflow and funding sources

	2022/23 £'000	2023/24 £'000	2024/25 £'000	2025/26 £'000	2026/27 £'000	2027/28 £'000	Total £'000
Costs							
Construction costs	0	0	0	1,803	42,054	14,200	58,058
Project fees	0	791	3,498	5,544	3,759	871	14,463
Non-works costs	7,990	268	962	825	310	8	10,362
Equipment costs	0	0	0	0	0	2,628	2,628
Planning contingency	0	0	0	1,746	5,891	2,945	10,583
Subtotal	**7,990**	**1,059**	**4,460**	**9,918**	**52,013**	**20,652**	**96,094**
VAT	0	0	192	874	9,651	3,178	13,895
Total capital costs	**7,990**	**1,059**	**4,652**	**10,794**	**61,664**	**23,830**	**109,989**
Funding							
Site purchase	7,990	10	0	0	0	0	8,000
RIBA 2	0	1,049	2,042	0	0	0	3,091
RIBA 3	0	0	2,013	1,486	0	0	3,499
Demolition	0	0	109	591	0	0	700
RIBA 4	0	0	0	2,828	0	0	2,828
Funding received to date	**7,990**	**1,059**	**4,164**	**4,905**	**0**	**0**	**18,118**
Construction	0	0	0	5,889	61,664	23,830	91,871
Funding still required	**0**	**0**	**0**	**5,889**	**61,664**	**23,830**	**91,871**
Total funding	**7,990**	**1,059**	**4,164**	**10,794**	**61,664**	**23,830**	**109,989**

As mentioned in section 7.2.2 in table 32, this OBC is requesting fees to take the programme from OBC approval to FBC approval and start on site, currently forecast to be late February 2026. The fee requested is contained in table 32 and excludes any works costs. This is why the funding balance differs slightly from that in Table 33 above. On FBC approval it is anticipated that the remaining 2025/26 funding of £3.712M will be required within the 25/26 CRL to avoid programme delay.

8.3 Revenue affordability

8.3.1 Recurring revenue costs

It is anticipated that the creation of the new diagnostics centre will incur additional recurring full year revenue costs of £9.3m p.a. related to the managed service contract with the ISP for the provision of equipment and delivery of services related to MRI, CT, NOUS, and Endoscopy. This is based on:

- Activity based on individual HB requirements included in the ISP procurement specification.
- ISP cost estimate currently based on 2025/26 NHSE CDC tariff.
- Case mix assumptions are based on 2024/25 CTMUHB activity.
- ISP procurement specification assumes seven-year contract with the option to extend for a further three years.
- Excludes depreciation and any IFRS16 implications (which are considered in section 9.4).

It is expected that the contract value will be reduced through the agreement of a tariff discount in return for the ISP's use of land and buildings. This has been estimated for the purposes of the OBC at £1.9m p.a.

It is also expected that activity and revenue costs will begin post completion and ISP commissioning of Phase 1 of the build. Whilst the main contractor build programme will complete at the end of June it is expected that the handover, equipping and commissioning could take up to four months, which is expected to be at the end of October 2027, which means the first year will incur five months of activity and revenue costs.

A summary of costs is provided below with more detailed calculations provided in Appendix 9 and 10.

Table 33 - Summary of revenue costs

Revenue element	2027/28 (assume opening - end of October 2027)	2028/29	2029/30 until end of ISP contract period
Activity	**No. of tests**	**No. of tests**	**No. of tests**
MRI	3,333	8,000	8,000
CT	5,000	12,000	12,000
NOUS	2,500	6,000	6,000
Gastroscopy	1,413	3,390	3,390
Colonoscopy	2,568	6,491	6,947
Sigmoidoscopy	250	763	992
Revenue costs	**£'000**	**£'000**	**£'000**
MRI	544	1,307	1,307
CT	518	1,242	1,242
NOUS	155	373	373
Gastroscopy	713	1,711	1,711
Colonoscopy	1,584	4,003	4,284
Sigmoidoscopy	107	326	423
Total ISP contract	**3,621**	**8,961**	**9,341**
Less: tariff discount for land	-724	-1,792	-1,868
Total ISP costs after discount	**2,897**	**7,169**	**7,473**

8.3.2 Commissioner funding requirements

Commissioner revenue funding requirements have been estimated for each of the three Health Boards based on projected activity assumptions at this stage, as outlined in the table below.

Table 34 - Activity assumptions

UHB	Revenue element	2027/28 [6]	2028/29	2029/30[7]
CTM	Activity	No. of tests	No. of tests	No. of tests
	MRI	3,333	8,000	8,000
	CT	5,000	12,000	12,000
	NOUS	2,500	6,000	6,000
	Gastroscopy	850	2,040	2,040
	Colonoscopy	1,360	3,264	3,264
	Costs	**£'000**	**£'000**	**£'000**
	Allocation of ISP contract costs	**2,486**	**5,965**	**5,965**
	Less: allocation of tariff discount for land	-497	-1,193	-1,193
	Allocation of revenue costs	**1,989**	**4,772**	**4,772**
C&V	Activity	No. of tests	No. of tests	No. of tests
	Gastroscopy	563	1,350	1,350
	Colonoscopy	1,208	2,900	2,900
	Sigmoidoscopy	250	600	600
	Costs	**£'000**	**£'000**	**£'000**
	Allocation of ISP contract costs	**1,135**	**2,726**	**2,726**
	Less: allocation of tariff discount for land	-227	-545	-545
	Allocation of revenue costs	**908**	**2,181**	**2,181**
AB	Activity	No. of tests	No. of tests	No. of tests
	Colonoscopy	0	327	784
	Sigmoidoscopy	0	163	392
	Costs	**£'000**	**£'000**	**£'000**
	Allocation of ISP contract costs	**0**	**271**	**651**
	Less: allocation of tariff discount for land	0	-54	-130
	Allocation of revenue costs	**0**	**217**	**521**

These assumptions will be firmed up at FBC stage once more detailed information is available and funding requirements adjusted accordingly. This results in a full year funding requirement of £9.3m p.a. (£7.5m per year after the proposed tariff discount) associated with the ISP contract, to be allocated as follows:

- CTMUHB £6.0m p.a. (£4.8m after the proposed tariff discount)
- C&VUHB £2.7m p.a. (£2.2m after the proposed tariff discount)
- ABUHB £0.7m p.a. (£0.5m after the proposed tariff discount)

[6] assumed opening - end of July 2027
[7] until end of ISP contract period

8.4 Accounting treatment and capital charges

8.4.1 Accounting treatment

The resulting asset will be held on CTMUHB's balance sheet and therefore be treated in line with the Health Board's policy in relation to depreciation and impairments.

8.4.2 Capital charges

Capital charges have therefore been estimated based on the following assumptions:

- Asset additions of £110.0m
- Impairment is applied when the resulting asset comes into use. Based on recent schemes in the region, specifically the Grange as a new build development at ABUHB, it is anticipated that this will be in the region of 20%, although this will need to be explored with the District Valuer and CTMUHB's Auditors during the development of the FBC stage. Full impairment is assumed on fees and non-works costs
- Depreciation charges are applied based on straight line depreciation using the following standard useful life:
  - **Buildings** – 60 years for buildings and 30 for engineering works (using a typical 65:35 split)
  - **Equipment** – seven years as a proxy for a mixture of short life ICT equipment (five years) and longer life equipment (10 years). This will be explored further at FBC stage when a costed equipment list is available.

It is anticipated that this will result in:

- Circa £48.0m non-recurring AME impairment on completion of the new build which will be funded as AME funding via Welsh Government
- £2.29m annual depreciation, which will be funded by Welsh Government.

8.4.3 IFRS16 implications

There will be IFRS16 implications associated with the external contract with the independent sector provider for Diagnostic Imaging and Endoscopy services. These will be calculated at FBC stage once more detail is available about equipment requirements and contractual arrangements. An estimate of these costs has been being provided via the WG required non cash returns.

8.5 Overall affordability

The financial analysis demonstrates that delivery of the preferred way forward is affordable providing that Welsh Government capital funding can be secured, and agreement reached with commissioners about revenue funding requirements.

8.5.1 Capital affordability

The cost plan prepared by CTMUHB's Cost Advisors, based on RIBA3a design, estimates that delivery of LHP will result in capital investment requirements of £110.0m in total, including expenditure incurred to date. It is anticipated that this will be funded as follows:

- £18.1m has been received, to date from WG, for:
  - Site purchase - £8.0m
  - RIBA 2 fees - £3.1m
  - RIBA 3 fees - £3.5m
  - Demolition - £0.7m
  - RIBA 4 fees - £2.8m

This includes funding of £2.828m which has been approved in August 2025 to support the phase 1 OBC redesign and the commencement of RIBA 4 works to support the FBC being completed for November Boards.

Further funding of £91.9m is therefore requested from Welsh Government for construction works.

8.5.2 Revenue affordability

Work undertaken to date by the programme team and finance leads, estimates that provision of services at LHP will incur recurring revenue costs of £9.3m for contracted out services for MRI, CT, NOUS, and Endoscopy.

It is expected that the contract value will be reduced through the agreement of a tariff discount in return for the ISP's use of land and buildings. This has been estimated for the purposes of the OBC at £1.9m per year.

These indicative costs are based on high level assumptions at this stage and will be firmed up at FBC stage once more detailed information is available.

This therefore results in a full year recurring revenue funding requirement of £7.5m. This has been allocated across the three Health Boards, based on projected activity assumptions which have been identified at this point in time, which equates to the following:

- CTMUHB £6.0m per year (£4.8m after the proposed tariff discount)
- C&VUHB £2.7m per year (£2.2m after the proposed tariff discount)
- ABUHB £0.7m per year (£0.5m after the proposed tariff discount)

It should be noted that should less activity be required funding requirements adjusted accordingly.

Management Case

9 Management arrangements

9.1 Introduction

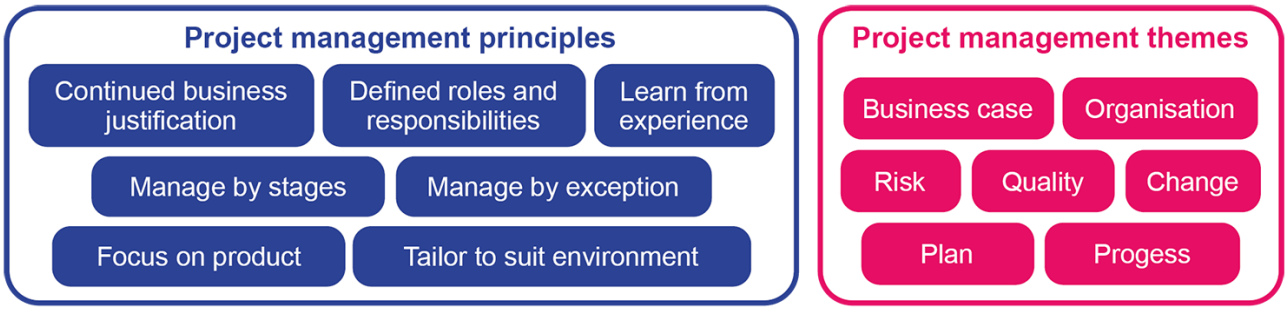
This section of the business case sets management arrangements that will successfully deliver Llantrisant Health Park Programme to time, cost and quality. The Management Case outlines the following arrangements:

- Project management arrangements
- Project assurance at different stages of the project
- Change management arrangements
- Benefits realisation and plans
- Risk management plans
- Contract management arrangements
- Post project evaluation plans
- Contingency plans.

9.2 Project management arrangements

The project will be delivered in line with PRINCE2 methodology. PRINCE2 is organised into seven principles and seven themes, which are deemed essential for any project to be deemed to be 'controlled'. This programme will apply these principles and themes throughout.

Figure 17 - Project management principles and themes



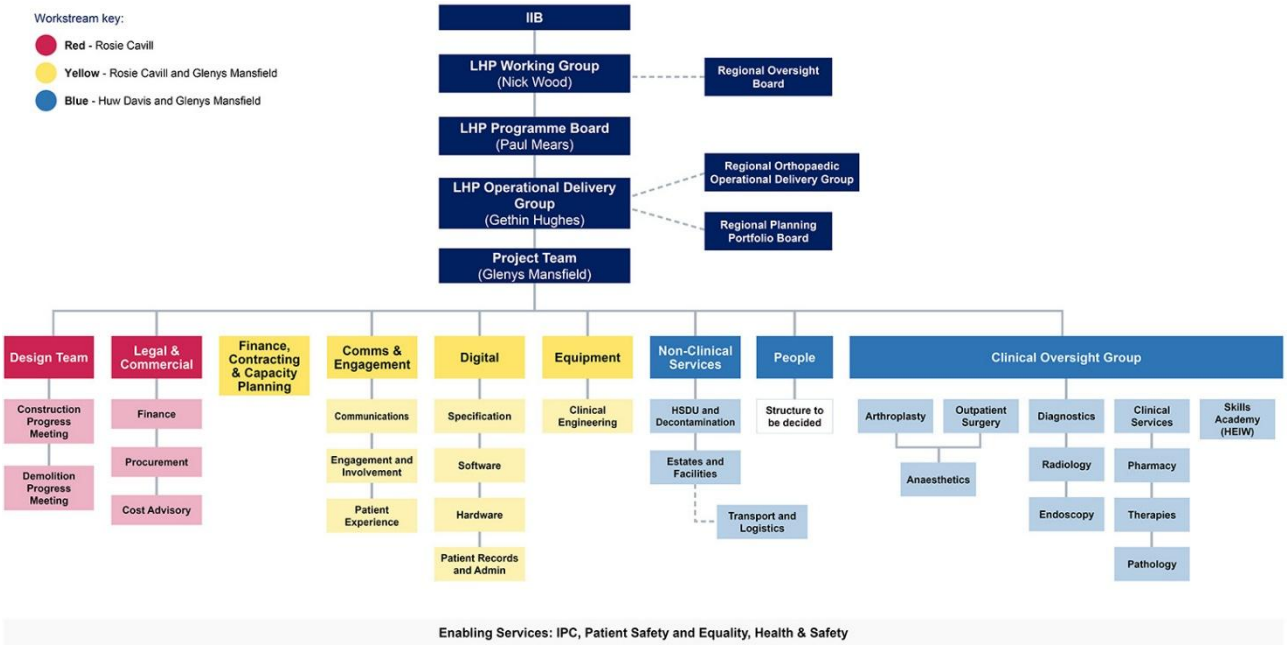
The key principles of PRINCE2 are the identification of three main functional areas of the project governance structure, including governance, delivery and assurance functions.

9.2.1 Project reporting structure

The programme governance structure has been established to reflect the principles and themes of controlled project delivery. The workstreams will report into the Project Team and Steering Group, Steering Group then reports into Programme Board which then reports to the Regional Oversight Board and CTMUHB Governance.

The project governance arrangements are outlined below.

Figure 18 - Project governance arrangements



9.2.2 Governance pathway

There is a clear demarcation between those groups with a responsibility to produce outputs needed to deliver the project i.e. workstreams and delivery groups, and those forums with responsibility to scrutinise, challenge and approve the outputs ensuring that the programme is directed consistently across all subject matters i.e. governance committees.

The main governance routes for reporting include CTMUHB Main Board and the Regional Portfolio Oversight Board.

9.2.3 Programme Board

Chair: Paul Mears, Chief Executive Officer and SRO for the Project, CTMUHB

The Llantrisant Health Park Infrastructure Programme Board has responsibility for overseeing the management and delivery of all aspects of this programme including the design proposals and the associated business cases.

The duties of the Programme Board are as follows:

- Ensure the programme objectives and scope of all projects have been appropriately defined and that any material changes are formally approved and integrated
- Ensure a robust programme timetable has been produced and monitored and that each workstream lead is committed and remains committed to its delivery
- Oversee the delivery of all projects within the defined parameters of time, cost and to the required quality and specification
- Ensure the cost implications of the programme are fully set out within robust financial plans and that it remains within the health board's overall affordability envelope
- Ensure there is an effective system of cost control in place and receive regular reports on the current and planned expenditure relating to the delivery of the programme
- Ensure that the programme is sufficiently resourced to deliver within its agreed scope, time, cost, and quality parameters
- Ensure there is an effective risk management system in place and that regular reports on the risks and issues are effectively acted upon

- Ensure that all development proposals meet the highest possible standards of design in respect of clinical use, patient and staff environment and building quality
- Sign off key documents including the clinical services strategy, business case, prior to submission to the IIB/Welsh Government for approval, as well as other key programme documents as required.

9.2.4 Programme Management Office

The Programme Management Office (PMO) is responsible for the oversight of all workstream project management within the programme. The PMO maintains internal reports and PRINCE2 documents including risk registers, issues logs and an assumptions log for the redevelopment. The team provides assurance by maintaining a focus on governance and programme controls and through the regular review and mitigation of risks and issues.

The programme plan is regularly reviewed and revised by the PMO team to accurately reflect progress, identify potential delays and ensure lessons learned are applied to planning. The PMO support resource management within the programme and produce project artefacts and tools for workstreams.

The duties of the PMO are as follows:

- Establish and run an effective PMO to support the programme during the business case process
- Establish and implement a robust governance structure
- Collate and interrogate management reports, assessing the health of the programme delivery environment
- Assess the status of milestones and deliverables from each workstream
- Plan and schedule resources efficiently in order to meet objectives
- Streamline and automate processes and workflows, ensuring escalation routes to governance committees are robust and succinct
- Facilitate knowledge transfers between workstreams
- Support project management resource within workstreams, where appropriate
- Facilitate cross stream working and collaboration
- Develop progress and assurance reports for key groups and committees as required.

9.2.5 Specialist workstreams and task and finish group

Included in the structure above (Figure 18) are specialist task and finish groups to support the clinical and non-clinical aspects of the redevelopment. These groups are the key interface between the delivery functions and the ‘front line’ workforce who deliver clinical and operational (non-clinical) services. The groups provide feedback and knowledge on their departmental requirements to the programme technical delivery experts.

9.2.6 Design Team

A design team has been appointed to review the concept site assumptions made prior to the site acquisition and develop design proposals. The design team’s work will be informed by the regional workstreams’ clinical specification and proposed models of care.

The key deliverables from this work are:

- Review of the technical infrastructure report (completed)
- A high-level design (RIBA Stage 1) and master plan (completed)
- A concept design (RIBA Stage 2) for the agreed clinical pathways (completed)
- RIBA 3 design works developing on the agreed clinical pathways (underway)
- Undertaking of site surveys (completed)
- A specification of enabling works for the temporary diagnostics facility (completed)
- Preparation of a temporary planning application for the mobile diagnostics facility (completed)
- Appointment of modular partner (completed)
- Confirmation of planning strategy and development of planning applications as required during the timeframe.

Terms of reference for all key project groups i.e. Programme Board, Steering Group, Project Team or Design Team can be made available upon request.

9.2.7 Outline project roles and responsibilities

Key Project delivery roles are described below:

Senior Responsible Officer (SRO)

The Chair/SRO role is held by **Paul Mears**, CEO of CTMUHB - responsibilities include:

- Keeping the Programme Board members informed of progress, escalating matters, as relevant
- Is responsible for providing leadership and the strategic activity of the Health Board, ensuring it is operating effectively and efficiently
- Being the ambassador within the local community and also at a regional and national level
- Ensuring that the programme aligns with the priorities of the wider Welsh Government plans
- Ensuring that the redevelopment programme fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money
- Sponsoring the project within CTMUHB and acts as the main point of contact with the Health Board and Executive Director
- Owning the vision for the project and the supporting business case
- Providing clear leadership and direction at an executive level throughout the programme
- Having full responsibility and accountability for the outcome of the project and realisation of the benefits
- Managing the interface with key senior stakeholders, keeping them engaged and informed
- Being the key link between the relationship between the programme, Regional Portfolio Oversight Board and Welsh Government;
- Maintaining the alignment of the project to the organisation's strategic direction
- Ensuring that the project remains affordable and will improve the quality of care to the target population
- Ensuring that the necessary resources are made available to deliver the scheme
- Chairing the Programme Board.

Infrastructure Programme Director

The Programme Director role is held by **Rosie Cavill**, LHP Programme Director - the main responsibilities include:

- Co-ordinating all workstreams to deliver the agreed objectives
- Monitoring progress, resolving issues, mitigating risks, and initiating corrective action as appropriate
- Providing an overall monitoring and assurance role across the project workstreams, ensuring that project risks and issues and any internal or external dependencies are defined, managed, and escalated where appropriate
- Ensuring appropriate risk, benefits and stakeholder management frameworks are in place for the project
- Acting as the day-to-day agent on behalf of the SRO for the infrastructure elements to ensure the successful delivery of the scheme
- Owning and reviewing the project plan, communicating the impact of any revisions in terms of milestones, timelines, and dependencies
- Ensuring the development of the business case and project documentation
- Ensuring that the initiatives and projects that support the infrastructure delivery of the Health Park are initiated on a consistent basis with governance arrangements that meet requirements
- Managing allocated outputs to the required quality within the agreed time and costs constraints
- Managing and providing assurance for the work of project team members
- Reporting regularly to all relevant individuals and groups using standard reporting processes and templates.

Clinical Operational Director

The Clinical Operations Director role is held by **Glenys Mansfield**, LHP Clinical Operations Director - the main responsibilities include:

- Clinical and operational pathway development to inform design and operational running of LHP
- Review of 1:200 and 1:50 designs
- Development of clinical governance structure
- Development of the workforce plan and delivery plan
- Development of the Digital infrastructure
- Establishing and managing task and finish groups
- Managing interdependencies of clinical model/pathways across workstreams
- Acting as the day-to-day agent on behalf of the SRO for the clinical pathway and operational elements to ensure the successful delivery of the scheme
- Ensuring that the initiatives and projects that support the delivery of the new hospital are initiated on a consistent basis with governance arrangements that meet requirements
- Ensuring appropriate risk, benefits and stakeholder management frameworks are in place for the project
- Reporting regularly to all relevant individuals and groups on clinical and operational pathway developments using standard reporting processes and templates.

Infrastructure Project Manager

The Infrastructure Project Manager role is held by **Alex Bowles**, Archus PM - the main responsibilities include:

- Ensure operational delivery of the project to time, quality, and budget
- Decision on matters for escalation and approval to Project Board and Health Board as required
- Management of risks and issues and escalation of appropriate matters for executive direction and/or approval
- Developing the format of the report, contents, and key requirements for consideration
- Planning and delivering stakeholder engagement and workshops
- Ensure the key milestones are agreed and communicated with all stakeholders.

Construction Partner

The role of Construction Partner Lead will be fulfilled by **MTX**. The role includes:

- Being point of contact for all infrastructure and estate related issues including arranging Isolations and issuing permits to work etc.
- Management of the construction programme
- Providing design/estates related input to OBC/FBC processes.

9.3 Special advisors – roles and responsibilities

Special Advisors have been used in a timely and cost-effective manner in accordance with the Treasury Guidance: Use of Special Advisors, to support the internal resources for this development. Special advisors and their roles on the project are shown below.

Business Case Support – Archus

- Manage the Business Case process including the facilitation of workshops, chasing of information etc.
- Stakeholder engagement
- Technical authoring of the OBC
- Support submission of OBC to WG
- Liaise with LHP Programme Lead on Business Case progress.

Technical Advisor (Architecture and Design) - Stride Treglown

- Providing design advice to the LHP Project Team on contractor lead design changes
- Liaise with appropriate stakeholders
- Preparing regular reports for the Project Manager.

Technical Advisor (Mechanical and Electrical Engineering) Stantec

- Providing technical advice and solutions to the Project/Design Team
- Liaise with appropriate stakeholders
- Assist with the design and construction teams where required
- Preparing regular reports for the Project Manager.

Cost Advisor – Mott MacDonald

- Full financial management and reporting of project costs together with payment recommendations for all expenditure incurred on the project
- Preparation of contract documents, procurement of contractors, payment of valuations and agreement of final accounts
- Budget estimating and cost modelling
- Cost planning
- Provision of cost advice
- Analysing and reporting on tenders received.
- Reporting and advising on all tendering and contractual arrangements
- Preparation of tender documents, including incorporation of client standard amendments and appropriate insurance provisions
- Preparing and issuing regular executive financial reports and cash flow summaries to the Project Manager.

Site Supervisor

To be appointed during RIBA 4

9.4 PM and professional fees budget

The following table outlines the estimated project and professional fees budget for the OBC.

Table 35 - Fees and non-work costs

Company	Purpose	Total fees spent incl. 20% VAT
Archus	Project Management	£1,069,127
Archus	Business Case Support	£20,250
Stride Treglown (ST)	Design Planning to RIBA 3a	£1,026,114
Mott Macdonald	Cost Advisor	£423,480
TBA	NEC Supervisor	£310,000
Stantec / ST	TA Support	£180,000
CTMUHB	Client Fees	£4,158,299
MTX	Construction (PSCP)	£8,555,529
MTX	*Planning*	*Incl. in MTX fees*
MTX	*Building Services; M&E and Surveys*	*Incl. in MTX fees*
Stride Treglown (MTX)	*Design Planning*	*Incl. in MTX fees*
Total		**£15,742,799**

9.5 Key milestones

A construction project programme has been developed to control and track the progress (attached at Appendix 11 and included in the estates annex) and delivery of the project and resulting outcomes. Key milestones for Phase 1 are summarised below.

Table 36 - Phase 1 project timeline

Milestone	Start	Completion
Confirm Scope and Develop OBC	14/07/2025	31/08/2025
Draft OBC Submitted to WG	05/09/2025	05/09/2025
HB OBC Approval	08/09/2025	15/10/2025
WG OBC Review and Approval	04/09/2025	16/10/2025
Planning Application	11/07/2025	15/10/2025
RIBA 4 and FBC Prep	28/07/2025	20/11/2025
HB FBC Approval and WG Submission	27/11/2025	27/11/2025
Scrutiny and WG FBC Approval	28/11/2025	23/01/2026
Contractor Mobilisation	23/01/2026	26/02/2026
Construction	01/03/2026	30/06/2027
Supplier Fit out of CDH	01/07/2027	31/08/2027
Commissioning	01/09/2027	31/10/2027

Indicative Milestones dates are also provided for the procurement of the ISP which should see them brought on line just at the completion of RIBA stage 4. It has been assumed that the ISP procurement is approved at IIB on 16th October alongside the Phase 1 OBC. In addition, whilst the date of the provider appointment is given it is anticipated that there will be a number of contractual negotiations during the construction phase. The ISP will become part of the design team moving forward so that programmes around equipping and commissioning can be fully aligned. It is anticipated that this may shorten the fit out and commissioning programme allowances however this cannot be confirmed at this stage.

Table 37 - ISP provider appointment timeline

Milestone	Start	Completion
ISP Tender Issue	18/08/2025	18/08/2025
ISP Tender Period	18/08/2025	19/09/2025
ISP Tender Evaluation	22/09/2025	03/10/2025
HB ISP Approval	06/10/2025	06/10/2025
WG ISP Procurement Approval	06/10/2025	16/10/2025
Intent to Award and Standstill Period	17/10/2025	31/10/2025
ISP Provider Appointment	31/10/2025	31/10/2025

9.6 Stakeholder engagement

9.6.1 Engagement to date

Key staff stakeholders across all health boards have been involved in design so far. RIBA 3 design review meetings were held in April and May 2025 to confirm all key stakeholders were agreed with current designs. In addition, the LHP Clinical team have worked closely with clinical users to ensure compliance with clinical standards and also with members of JAG compliance teams to ensure compliance.

9.6.2 Future communications and engagement

A communications and engagement group will be put in place to manage the engagement, consultation and communication processes for the regional Diagnostic Programme. This group will consist of communications and engagement leads for each health board, service leads and other colleagues to be co-opted as required.

The communications and engagement plan will be supported by the following key steps:

- Facilitating and supporting stakeholder identification, mapping and analysis
- Engagement with patients, clinicians, staff and the public to discuss and explore issues, refine and evaluate proposals, and decide which questions to consult on. This includes the proposed pre- engagement activity to assess the public's views on the development of diagnostic services (endoscopy and radiology) delivered outside of an acute hospital setting on both a local and regional level, and to identify their needs and any barriers they face in accessing services.
- Focused formal consultation on fully evaluated proposals will last a minimum of six weeks
- Communication of agreed changes to key stakeholders, organisation-wide staff groups, and the public – it should be noted that this activity does not replace management communications with specific teams.

In developing and delivering our communications and engagement activities we will:

- Maintain stakeholder and public confidence in the LHP as a landmark development that will improve the provision of modern health care in south-east Wales
- Provide the public with a range of opportunities to inform the development of the LHP in ways that maximise access, clinical effectiveness and the experience of patients
- Take a collaborative approach, with NHS partners, to developing and disseminating messages and communications/engagement resources, that enable consistency, clarity and accuracy across the region and nationally
- Identify and promote opportunities to add social value within local communities
- Identify and celebrate programme milestones, alongside partners
- Involve local political partners and relevant third-sector organisations
- Provide assurance to the programme board and national bodies on the effectiveness of communications and engagement activities and seek to continually improve.

9.6.3 Involving and engaging the public

It is important that those communities who will benefit from the LHP, are provided with meaningful opportunities to inform the ways in which they will experience, and access healthcare and support provided from the facility.

Working in partnership with Llais, and through collaboration across NHS partner organisations, we are developing approaches and resources that enable people to be engaged and involved in a range of ways, recognising and respecting barriers and protected characteristics, and adhering to best practice and law including the Llais Service Change Protocol as appropriate.

We will take a continual involvement approach that seeks to embed the patient voice into the structure of the programme and the development of the facility. This may include the formation of a citizens' panel which would include representation from different communities across the region.

9.7 Project assurance

The current governance structure allows for a clear separation between governance functions and those that deliver or approve outputs. The assurance functions will confirm that the processes and procedures followed by the delivery groups have been sufficient and in accordance with sound management principles. The assurance function will also act as the coordination point between the delivery and governance functions. Within the PRINCE 2 governance arrangements the PMO is classed as part of the Assurance function.

Programme

- Review of upcoming programme activity and milestones with LHP Technical PM and Project Director to determine outputs required by workstreams
- Create lookahead programme highlighting key programme deliverables over coming weeks/months for dissemination to workstreams
- Track workstream output and performance toward achieving programme deliverables and feed progress into monthly reporting – PMO drumbeat.

Risk

- Review of risk with LHP Technical PM and Project Director to review and update risk register based on workstream risks
- Track workstream risks and feed into project reporting – PMO drumbeat.

Key Performance Indicators (KPIs)

- Work with LHP Project Director to determine workstream KPIs
- Track workstream KPIs and feed into project reporting – PMO drumbeat.

9.8 Change management

The Health Boards are aware that the project will cause major change for staff working in the area and across all three Health Boards, and therefore its success is predicated on staff supporting the project. To date, key staff have been involved in workshops regarding clinical flows and design, and it is envisaged that they will continue to play an instrumental role as the project moves into its next phase. Prior to the new facilities opening, detailed planning will be undertaken to understand any changes to ways of working, and staff will be supported by the project team to prepare for this. Transition plans will be developed, in collaboration with relevant stakeholders, to ensure the new facilities run smoothly and that staff are prepared for any resulting changes to their working models

There will be no change to organisational structures following completion of the development. There is potential for positive cultural changes following completion to enable staff to work more effectively and efficiently in a new fit-for-purpose building. This can help contribute to higher levels of staff retention over the coming years to improve the working culture for both staff and patients.

Within each stage there will be a series of decision points where major documents produced by workstreams will be ratified within the governance arrangements. For example, clinical advice leaflets pre/post day surgery. All documents will be subject to a robust and consistent version control methodology.

All changes will be subject to a formal change control process. Change is not design development. Change can only occur when strategic, operational policies or functional content quantities are altered from those included in the current approved documents. Change management associated with the infrastructure aspects of this project will be managed by the LHP Project Team through Programme Board and Regional Oversight Board.

9.9 Contingency plans

Should the current scheme fail to proceed, the only contingency plan would be to continue with business as usual for services regionally, working with wait list initiatives or temporary diagnostic solutions such as mobile MRI when required to meet additional demand.

9.10 Benefits realisation

A Benefits Realisation Plan will be developed by the Programme Board to put in place the necessary arrangements to ensure that the project delivers its anticipated benefits. This includes setting out the arrangements for planning, modelling and tracking the identified benefits as well as a framework that assigns responsibility for the realisation of the benefits throughout key phases of the project. The Benefits Realisation Plan will be owned jointly by the Health Board's Infrastructure and Clinical and Operational Programme Directors.

The main benefits for the preferred option are outlined in the benefits register included in Appendix 6 while the actions required to realise the benefits will be confirmed at FBC stage.

The spending objectives and aligned benefits used in the selection of the preferred option will be used to measure the project success.

This evaluation process will be run in parallel with the Post Project Evaluation Plan as noted below and will be developed as part of the detailed design stage. The Benefits Realisation Plan will be regularly reviewed and updated. This will ensure that – should any strategic change take place, such as a legislative change – the service and project will be flexed accordingly to ensure that the facility delivers a fit for purpose service from the point of operational commencement.

The benefits realisation approach outlined above is a key output to provide assurance on investment delivery and performance and will be shared with the Health Boards and Welsh Government to facilitate shared learning at FBC stage.

9.11 Risk management

The complexity of the LHP programme necessitates an appropriate risk management process is put in place to identify, assess and mitigate the likelihood of risks materialising throughout the programme duration.

Workstream risks are those which are considered by each workstream as a risk to successful delivery of business outcomes and targets. They vary from seemingly insignificant risks to risks which are potentially very damaging. Where risks are deemed to be significant (residual rating >12) and occur across several workstreams these are considered as programme risks and dealt with accordingly.

Risk management is therefore dealt with in a two-tier system approach:

- Workstream risk management is an iterative process undertaken by workstream leads, with a monthly reporting cycle up to the LHP Steering Group. All workstreams will be issued a risk register template to log their risks and issues
- Programme risk management is an iterative document that is reviewed monthly in the Programme Board and Steering Group meetings and updated to reflect any changes that may impact programme scope, cost, timeliness, quality, or designs.

Should any risks be identified through the programme that have an impact on the Health Board service delivery and / or strategic direction then it should be escalated via the SRO to the Assistant Director of Governance and Risk for inclusion and scrutiny on the Organisational Risk Register.

9.11.1 Consequence and likelihood definitions

The below tables include the initial definitions relating to the consequence and likelihood of a risk occurring. These definitions are used for both workstream-level risks that are maintained in the dashboard report *and* the programme levels risks that are reflected in the programme risk register.

*Table 38 - Risk **consequence** definitions*

Score	Descriptor	Actual or potential impact on the individual/service or organisation
1	Negligible	• Minimal injury requiring no/minimal intervention or treatment. • Potential for public concern • Insignificant cost increase/ schedule slippage • Minimal or no impact on the environment
2	Minor	• Minor injury or illness, requiring minor intervention. • Local media coverage – short-term reduction in public confidence • <5% over project budget, schedule slippage • Minor impact on the environment
3	Moderate	• Moderate injury requiring professional intervention. • Local media coverage – long-term reduction in public confidence • 5 – 10% over project budget, schedule slippage • Moderate impact on the environment
4	Major	• Major injury leading to long-term incapacity/disability • National media coverage with <3 days service well below reasonable public expectation • 10-25% over project budget, schedule slippage, key objectives not met • Major impact on the environment
5	Catastrophic	• National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) • Incident leading to > 25% over project budget, schedule slippage, key objectives note met • Catastrophic impact on the environment

*Table 39 - Risk **likelihood** definitions*

Score	Descriptor	Likelihood of occurrence
1	Rare	This will probably never happen/recur
2	Unlikely	Do not expect it to happen/recur but it is possible it may do so
3	Possible	Might happen or recur occasionally
4	Likely	Will probably happen/recur but it is not a persisting issue
5	Almost certain	Will undoubtedly happen/recur, possible frequently

9.11.2 Risk matrix

The risk matrix shown below is also consistent between both levels of risk management. The Health Board risk matrix is shown below.

Figure 19 - Risk scoring matrix (Likelihood x Consequence = Risk score)

		Consequence				
Likelihood	**Frequency**	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Highly unlikely: will probably never happen	not for years	1	2	3	4	5
2 Unlikely: not expected to happen / recur, but is possible	at least annually	2	4	6	8	10
3 Likely: might happen / recur occasionally	at least monthly	3	6	9	12	15
4 Highly likely: will probably happen / recur, but not a persistent issue	at least weekly	4	8	12	16	20
5 Almost certain: will undoubtedly happen / recur, possibly frequently	at least daily	5	10	15	20	25

Risks should be assessed and reviewed on a regular basis, as determined by their score:

1-6 Low	Low risks should be reviewed and progress on actions recorded and updated at least every 6 months
8-12 Moderate	Moderate risks should be reviewed and progress on actions recorded and updated at least quarterly
15-25 High	High risks should be reviewed and progress on actions recorded and updated at least every 2 months; if scored 20 or over the risk should be reviewed each month

The following management actions are taken for each category:

- **Red** – Reviewed at every Steering Group and Programme Board meeting with clear and determined action reviews in each pertinent workstream. Workstream leads are predominantly identified as the risk owner;
- **Amber** – Reviewed regularly and appropriate review dates are agreed at workstream groups/committees. The risk owner should be a senior member of the pertinent workstream; and
- **Yellow and Green** – Reviewed regularly to ensure the likelihood and/or consequence of the risk arising has not risen. Risk ownership can be assigned to anyone on the pertinent workstream.

9.12 Contract management

Robust contract management process will be put in place to oversee both the construction contracts and the managed service contracts with the ISP. The use of regular reviews and KPI monitoring will be critical to managing and overseeing performance throughout contract durations.

9.13 Post-project evaluation

Post-project evaluation (PPE) is a mandatory requirement for infrastructure projects that receive Welsh Government funding. The purpose of PPE is to improve project delivery through lessons learned during the project delivery phase and to appraise whether the project has delivered its anticipated outcomes and benefits.

The Health Board and its partners are committed to ensuring that a thorough and robust post-project evaluation is undertaken at key stages in the process to ensure that lessons are learnt. The PPE also sets in place a framework within which the benefits realisation plan set out in section 10.11 can be tested to identify which benefits have been achieved and which have not.

The Health Board is exploring opportunities to work with a local university in carrying out the PPE. Detailed plans will be drawn up in partnership with the university. The evaluation will be carried out in line with NHS guidance, and will measure the project against the following factors:

- The extent to which the original objectives have been met
- Measurement against the Benefits Realisation Plan
- Risk allocation
- Timetable
- The cost of the project and the extent to which it can demonstrate value for money
- The Project outcome compared with the ‘Do Nothing’ or ‘Do Minimum’ scenarios
- User satisfaction
- Procurement route
- The economic viability of the project in comparison with the ‘Do Nothing option
- Functional Suitability – how the facility performs
- Functional Relationships – how well the various process flows (staff, patient, service) work.

We envisage four key stages to the evaluation, outlined as follows:

Stage 1: Project procurement

The objective of the evaluation at this stage is to assess how well the project was managed from the time of OBC approval to commencement of the construction phase. It is planned that this evaluation will be undertaken within three months of construction commencement. The evaluation at this stage will examine:

- How effectively the project was managed
- The quality of the documentation prepared by the Health Board and its partners
- Communications and involvement during procurement
- The effectiveness of advisers used on the scheme
- The efficacy of NHS guidance in delivering the scheme.

Stage 2: Implementation

The objective of this stage is to assess how well the project was managed from the time the construction phase commences through to commencement of operational commissioning.

It is considered that this should be undertaken three months following operational commissioning of the unit. The evaluation at this stage will examine:

- How effectively the project was managed
- Communications and involvement during construction
- The effectiveness of the joint working arrangements established by the Contractor, the design team and the project team.

Stage 3: New operational model in place

The objective of this stage will be to assess how well the project was managed during the operational commissioning phase, through to operation in the new building. It is proposed that this stage will be undertaken up to 12 months after completion of operational commissioning of the scheme. The evaluation at this stage will examine:

- How effectively the project was managed
- Effectiveness of the new operational model
- Communications and involvement during commissioning, and into operations
- Overall success factors for the project in terms of cost and time
- Extent to which the new operational model meets users' needs – from the point of view of patients, carers and staff.

Stage 4: New operational model well-established

It is proposed that this evaluation is undertaken 18 months following completion of operational commissioning. The objective of this stage will assess how well and effectively the project was managed during the actual operation of the new Health and Wellbeing Centre. The evaluation at this stage will examine:

- Effectiveness of the new operational model
- Extent to which the new operational model meets users' needs – from the point of view of patients, carers and staff.

The evaluation process will be managed by the Project Manager via a bespoke team established to oversee the PPE. Evaluation reports will be made available to all relevant stakeholders, including Welsh Government.

Report Title:	Monthly Monitoring Return – Month 3			Agenda Item no.		4.1
Meeting:	Finance and Performance Committee		Public	x	Meeting Date:	17.09.2025
			Private			
Status:	Assurance	x	Approval		Information	
Lead Executive:	Executive Director of Finance					
Report Author:	Deputy Director of Finance					

Background and current situation:

SITUATION

WHC (2025) 023 - 2025/26 NHS Wales Financial Monitoring Return
Guidance requires the UHB to provide a main Committee of the Board with copy of the monthly Financial Monitoring Return (consisting of the Narrative, Table A and Tables C to C3), to provide the Committee with transparency on the submission made to the Welsh Government.

A copy of the June 2024/25 MMR is attached.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The extracts from the UHBs Monthly Financial Monitoring Return are provided for information and assurance.

Appendices: (please list all appendices that accompany this report. Do not embed)

- 4.1a CV Financial Monitoring Returns 2025-26 - Month 3
- 4.1b 2024-25 MMR Template - Cardiff Vale UHB Month 3

Recommendation:

The Board/Committee are requested to:

a) NOTE the extracts from the UHBs Monthly Financial Monitoring Returns.

Link to Strategic Objectives of Shaping our Future Wellbeing:

https://shapingourfuturewellbeing.com/

1. Putting People First **Click the objective above to view more detail.**		2. Providing Outstanding Quality **Click the objective above to view more detail.**	
3. Delivering in the Right Places **Click the objective above to view more detail.**		4. Acting for the Future **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered									
Prevention		Long term		Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?				
Yes –		No – ***(Please provide reasoning, e.g. not required)***	X	N/A

Impact Assessment:
Risk: No
Safety: No
Financial: Yes
Workforce: No
Legal: No
Reputational: No
Socio Economic: No - ***Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: The Socio-economic Duty: guidance | GOV.WALES***
Equality and Health: No
Decarbonisation: No
Welsh Language: Yes/No

Approval/Scrutiny Route *(please note anywhere else this paper has been **before**):*	
Committee:	Date:

THE WELSH GOVERNMENT FINANCIAL COMMENTARY

FINANCIAL POSITION FOR THE THREE MONTH PERIOD ENDED 30th JUNE 2025

INTRODUCTION

The Health Board submitted an initial draft financial plan to the Welsh Government at the end of March 2025.The draft plan incorporated: -

- Brought forward underlying deficit of £59.9m
- 2025/26 Demand and cost growth and unavoidable investments of £51.1m
- Additional Allocations of £20.3m
- Anticipated pass-through funding on Long Term Agreements of £2.5m (1.77%)
- A £30.0m Savings programme

This results in a 2025/26 planning deficit of £58.2m which has now been amended to £56.2m as a result of the additional £2m savings target actioned in year

The draft plan assumes that:

- The costs of the Real Living Wage (RLW), being paid to staff directly employed by the UHB, will be funded through the 2025-26 pay award funding in addition to the non recurrent funding for the impact of the policy on the social/third sector.
- The additional £18.8m of costs related to changes to the Employers NI rates will be fully funded.

A summary of the revised draft financial plan submitted is provided in Table 1.

Table 1: 2025/26 Draft Plan

Planning Assumptions	(£m)
Brought Forward Underlying Deficit	59.900
2025/26 Demand/Cost Growth/Improvement	51.100
Draft Deficit	**111.000**
Additional Allocations	(22.768)
Savings Plans	(30.000)
Initial Planned Deficit	**58.239**
Additional In Year Savings Plans	(2.000)
Revised Planned Deficit	**56.239**

This represents the draft financial plan of the Health Board.

These financial monitoring returns have been prepared within the framework of the UHB's revised Draft Financial Plan, which includes a planning deficit of £56.233m for 2025-26. This report details the financial position of the UHB for the period ending 30th June 2025.

A full commentary has been provided to cover the tables requested for the month 3 financial position.

At month 3 the UHB is reporting an overspend of £15.216m.

This is comprised of £0.844m unidentified savings, £0.314m of operational deficit and the planned deficit of £14.058m (3 twelfths of the revised £56.2m 2025/26 planned deficit set out in the UHB's Accountable Officer letter relayed on the 30th June 2025).

BACKGROUND

The Board noted and submitted a draft financial plan to the Welsh Government at the end of March 2025. Following the submission of the plan, Welsh Government asked the UHB to detail further actions to reduce the forecast deficit of £58.2m. In response, the UHB confirmed that progress in the identification of savings provided the UHB with sufficient assurance to increase planned savings delivery by £2m which in turn has reduced the forecast 2025/26 deficit position to £56.2 million.

MOVEMENT OF OPENING FINANCIAL PLAN TO FORECAST OUTTURN and UNDERLYING POSITION (TABLE A & A1)

Table A sets out the draft financial plan and latest position at month 3 for which the following should be noted:

- The UHB's initial £30.0m 2025/26 savings target is reported on lines 6,7 & 11. The forecast achievement of the further target of £2.0m is also reported on lines 6,7 & 11 with the further £2m schemes required to meet the £32m target being reported on line 24.
- It is assumed that LTA inflation of £2.471m (1.77%) will be passed to the UHB from other Health Boards (line 4).
- The bought forward underlying deficit is £59.9m as outlined in the draft financial plan.

The identification and delivery of the £32.0m recurrent savings target is key to delivery of the planned in year and underlying position.

OVERVIEW OF KEY RISKS & OPPORTUNITIES (TABLE A2)

Table A2 reflects a review of the risks identified in the financial plan and these will continue to be reviewed on a monthly basis. In addition, the table also reflects the shortfall in funding for the additional employer changes arising from changes in pay and employers NI rates £1.428m as well as the potential further Risk Pool liability of £6.639m arising from the indicative apportionments of the £42m increased risk associated with the WRP claims that are forecast to settle in 2025/26. The potential opportunity arising from the Microsoft DHCW Review is also noted. The potential additional cost of band 2 & 3 pay costs is also noted.

ACTUAL YEAR TO DATE (TABLE B AND B2)

Table B confirms the year to date deficit of £15.216m and reflects the analysis contained in the annual operating plan in Table A. The deficit of £15.216m for the year to date as shown in Table 2.

Table 2: Summary Financial Position for the period ended 30th June 2025

	Plan PTD (£m)	PTD (£m)	PTD Variance to Plan (£m)	Plan YTD (£m)	YTD (£m)	YTD Variance to Plan (£m)
Draft Plan	5,372	5,372	0	19,349	19,349	0
Quality Efficiency Improvement Plans - Savings	(2,394)	(2,135)	259	(5,291)	(4,447)	844
Operational Variance	0	79	79	0	314	314
Clinical/Service Board Variance	**2,979**	**3,317**	**338**	**14,058**	**15,216**	**1,158**

The month 3 deficit of £15.216m comprised of the following:

- £14.058m planned deficit
- £0.844m unachieved CRP gap
- £0.314m adverse operational variance against plan.

At Month 2, there was a difference between the formally reported deficit against plan of £0.812m and the deficit against plan reported in the leadership board paper being £2.2m. This difference was due to the actual profile of the £58.2 deficit compared to a flat profile. The UHB can confirm that at month 3 the £58.2m (£56.2m) deficit is now profiled flat so there should be no differences in the reported variance to plan.

It is anticipated that the unachieved CRP gap at month 3 will be recovered as the year progresses and that the UHB will deliver its planned deficit position of £56.200m.

Executive Performance Reviews with the UHBs Clinical Boards focus on ensuring that both planning and operational pressures are identified and managed as they arise. In addition, the UHB remains focussed on tracking delivery against its savings plans whilst identifying opportunities for further improvements through weekly Senior Leadership Team meetings and dedicated financial summits. that in turn will de-risk the draft financial plan.

The UHB financial plan has been established at a Clinical Board level with each Board working towards an agreed control total based on the following:

- Underlying Deficit b/f to 2025-26
- Cost Growth
- Demand/Volume Growth
- Commissioning pressures
- Allocation of 1.77% Welsh Government Uplift against assessed Growth and Pressures
- Quality Improvement Programmes (savings)

A number of operational pressures have continued into month 3, which in turn have been partly offset by non recurrent operational underspends across service areas. The following operational issues were reported in month 3:

- Income – Underperformance is reported against CAVOC LHB provider contracts based on month 2 activity. Underpeformance is reported against income in St Marys pharmacy Unit and Radio-pharmacy where performance is expected to regress towards the mean as the year advances. **In addition, there is reported underperformance in cardiac services where the UHB is reviewing activity against the previous years delivery**. This is partially offset by income in other patient areas where activity is above seasonal trends.

- Pay – vacancies in Estates, Executive functions & PCIC along with enhanced scrutiny around variable pay has offset pressures against medical staff where additional costs are being incurred to cover vacancies, Less Than Full Time (LTFT) posts and sickness.
- Non Pay – Continuing pressures are reported against Mental Health Out of Area (OOA) referrals where numbers have reduced but the acuity remains high.
  In addition, continuing water leaks on UHB sites due to deterioration of the Estate are driving an operational pressure.
- variance associated with the shortfall in NI funding is reported against non pay at £0.358m for the year to date.
- Some of the pressures are mitigated by a surplus against the initial assessment of prescribing growth. This will be closely monitored as the financial year progresses and is currently based on April data.

In relation the material pressures the following work is being progressed

- Medical Pay - Clinical Boards are reviewing medical pay at directorate level to determine if there are more efficient ways to cover rota gaps
- Mental Health OOA - The Clinical Board is reviewing Bed Flow twice daily and further Investigating options to reduce the volume and cost of OOA. The UHB has initiated initial conversations with health boards about the development of a national capacity plan focusing on provision for specialist mental health services across Wales

Table B2 – Movements from Opening Expenditure Plan

Following the submission of the draft financial plan, the UHB has reviewed and reassessed its resource limit assumptions as oulined in Table 3 below. The main change in assumptions relates to the £18.8m additional costs arising from changes in Employer NI rates and threshold values alongside confirmation of DPIF prgramme funding and the impact of the Real Living Wage increase on the cost of UHB employees at bands 2 & 3

Table 3 – Additional Resource Limit Assumptions

Additional Resource Limit Allocations	£'000s
25_26 NIER Additional 1.2% and Threshold Change	16,697
ARRP	109
CAMHS In-Reach Funding	622
Consultant Clinical Excellence Award / Consultant Impact Award	347
DEL Non Cash Depreciation - IFRS 16 Leases	3,079
DEL Non Cash Depreciation - Accelerated	1,979
ESMCP Control Room	116
ESMCP WAST Resources	38
Climate Focussed Spead and Scale Academy	52
Neighbourhood District Nursing	137
New Medical Training Posts 2017 to 2024	283
Pay award funding 2024-25	(5,069)
Dementia Connector	100
Short Breaks for Carers	172
RTT Waiting Times _ Q1 Plans	2,783
DPIF Programmes	3,777
RSV Vaccination Programme	246
Support staff costs - All Wales Pharmacogenetics lead post	96
DOLS / MCA / advocacy (MH)	256
JCC English contracting income	(309)
MOD St Athan funding Lazurite Team additional reception site for EPS	(282)
Invest To Save - Welsh Government energy service	(347)
All Wales international recruitment	7
Women's Health - Pathfinder Establishment (women's health hubs)	300
Individual placement & support in primary care	440
Prevention and early years AHW - early prevention	43
Real Living Wage RLW 2025_26	3,344
Consultant Allied Health Professional for dementia	30
Genomics (CaV_JCC)	323
Planned care transformation fund	564
Secondment fb work on medical gases activities	4
Children's speech, language and communication (slc)	34
Planned care additional funding 2025-26 - phase 3 outpatients	193
Community pharmacy pilot injectable larc for contraceptive purpose	10
Decabonisation secondment fb	28
Planned care transformation fund	107
Ame non cash depreciation - ifrs 16 leases (peppercorn)	(8)
Ame non cash depreciation - donated assets	(308)
Ame non cash depreciation - impairment	30,341
Del non cash depreciation - ifrs 16 leases	(9)
Removal of donated assets / government grant receipts	(521)
Removal of ifrs-16 leases (revenue)	170
Ame non cash depreciation - donated assets	140
Awttc voluntary scheme for branded medicines pricing, access and growth (vpag) ir	600
Del non cash depreciation - baseline surplus / shortfall	(3,376)
Neurodivergence improvement programme	158
Total Movement in assumed Resource Limit follwing MDS Submission £'000s	**57,496**

PAY & AGENCY (TABLE B2)

The UHB recorded Agency costs of £0.350m in month primarily due to nursing pressures. £0.125m of the costs recorded in May related to registered nursing and midwifery and a further £0.130m to allied Health Professionals.

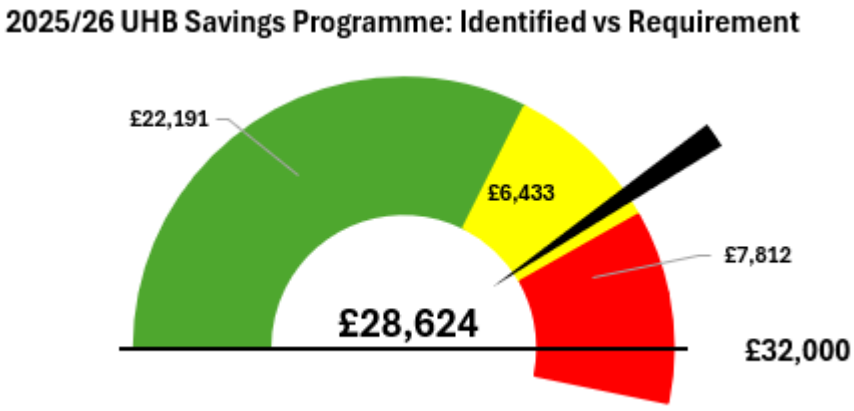
Agency Costs have reduced from an monthly average of £0.507m in 2024/25 to £0.344m in 2025/26 as a result of enabling actions taken to manage down UHB agency usage.

Savings Programme 2025-26 (TABLE C, C1, C2, C3 & C4)

At Month 03, the UHB had identified £28.624m (89.5%) of green and amber savings to deliver against the revised £32.0m savings target. Red schemes of £7.812m are also identified and continue to be reviewed for progression to Green/Amber where possible.

The reported gap of £3.376m in identified savings incorporates red schemes and the unidentified balance. Red schemes are excluded in accordance with the instruction from Welsh Government that red schemes are not included in the Monthly Monitoring Returns savings tables. Graph 1 below outlines progress in the identification of Savings Schemes.

Graph 1 – Progress in the Identification of Savings Schemes



INCOME/EXPENDITURE ASSUMPTIONS (TABLE D)

NHS organisations are expected to have concluded discussions and signed contracts (Long Term Agreements and Service Level Agreements) between each other by June 12th, 2025.

The UHB has completed discussions to agree contract activity and financial values for all Long Term Agreements (LTA) and Service Level Agreements with other Welsh NHS LHBs

The UHB has agreed the 2025-26 LTA agreement with JCC. Documentation had been finalised and agreed between both parties and has been forwarded to Chief Executives for. respective signatures

INCOME ASSUMPTIONS 2025/26 (TABLE E)

Table E outlines the UHB's 2025/26 resource limit.

Similar to practice in previous years, the UHB reported position continues to exclude recurrent expenditure which has arisen following a change in the accounting treatment of UHB PFI schemes under International Financial Reporting Standards (IFRS). The UHB is assuming that Welsh Government will continue to provide resource cover for this cost, which was assessed at £0.222m in the previous financial year.

The UHBs confirmed /Revenue Resource Limit as of Jun 30th, 2025, was £1,343m with a further £146.7m of assumed allocations as detailed at Table 4 below:

Table 4 – Unconfirmed Resource Limit Allocations as of 30th June 2025

Unconfirmed Resource Limit Allocations as of 30th June 2025	£'000s
Depreciation, Impairments & IFRS 12	34,731
Pay Award funding 2024-25	64,482
25_26 NIER Additional 1.2% and Threshold Change	16,697
Vertex (JCC)	6,894
Real Living Wage (Care Homes)	6,180
Pay Award Funding Real Living Wage RLW 2025_26 - Additional Employer Costs	3,344
Urgent & Emergency Care Fund	2,960
RTT Waiting Times _ Q1 Plans	2,783
Consultant Clinical Excellence Award / Consultant Impact Award	2,143
New Medical Training Posts 2017 To 2024	2,019
ATMPs (JCC)	1,944
GP Im&T Refresh Programme	1,225
Prevention And Early Years AHW - Early Prevention	881
Neurodivergence Improvement Programme	793
AWTCC Voluntary Scheme For Branded Medicines Pricing, Access And Growth (VPAG) Investment	600
Planned Care Transformation Fund	565
A2A Sanctuary	503
Integration And Rebalancing Capital Fund (IRCF)	450
Individual Placement & Support In Primary Care	440
Genomics (C&V / JCC	323
Women's Health - Pathfinder Establishment (Women's Health Hubs)	300
Welsh Risk Pool	(5,702)
Other	2,151
Total Anticipated Funding £'000s	**146,706**

This level of unconfirmed allocation (£146.7m less the £37.6m depreciation funding) will present a cash management risk to the UHB if it remains outstanding into the Autumn period and when it is combined with the forecast financial deficit (£56.2m) alongside the requirement of the UHB to fund multi-million pound clinical negligence settlements instructed by the Welsh Risk Pool (WRP). Reimbursement for WRP instructed payments is always received in arrears of payment.

BALANCE SHEET (TABLE F)

The Opening Balances at the beginning of April 25 reflect the closing balances in the 2024/25 Final accounts.

Property, plant & equipment is in line with the start of the year. This is due to capital purchases combined with the impact of monthly depreciation charges.

The forecast balance sheet reflects the UHB's latest non-cash estimates and its anticipated capital funding.

MONTHLY CASHFLOW FORECAST (TABLE G)

The closing cash balance at the end of June, was £4.196m.

In due course, the UHB expects to seek Finance Committee and Board approval to request £58.2m strategic cash support from Welsh Government to cover the cash shortfall arising from the forecast deficit.

The level of unconfirmed drawing limit allocation (£146.7m less the £37.6m depreciation funding) will present a cash management risk to the UHB if it remains outstanding into the Autumn period and when it is combined with the forecast financial deficit (£56.2m) alongside the requirement of the UHB to fund multi-million pound clinical negligence settlements instructed by the Welsh Risk Pool (WRP). Reimbursement for WRP instructed payments is always received in arrears of payment.

Table 5: Summary of unconfirmed drawing limit allocations as at 30th June 2025

Unconfirmed Resource Limit Allocations as of 30th June 2025	£'000s
Depreciation, Impairments & IFRS 12	(2,864)
Pay Award funding 2024-25	64,482
25_26 NIER Additional 1.2% and Threshold Change	16,697
Vertex (JCC)	6,894
Real Living Wage (Care Homes)	6,180
Pay Award Funding Real Living Wage RLW 2025_26 - Additional Employer Costs	3,344
Urgent & Emergency Care Fund	2,960
RTT Waiting Times _Q1 Plans	2,783
Consultant Clinical Excellence Award / Consultant Impact Award	2,143
New Medical Training Posts 2017 To 2024	2,019
ATMPs (JCC)	1,944
GP Im&T Refresh Programme	1,225
Prevention And Early Years AHW - Early Prevention	881
Neurodivergence Improvement Programme	793
AWTCC Voluntary Scheme For Branded Medicines Pricing, Access And Growth (VPAG) Investment	600
Planned Care Transformation Fund	565
A2A Sanctuary	503
Integration And Rebalancing Capital Fund (IRCF)	450
Individual Placement & Support In Primary Care	440
Genomics (C&V / JCC	323
Women's Health - Pathfinder Establishment (Women's Health Hubs)	300
Welsh Risk Pool	(5,702)
Other	2,151
Total Anticipated Funding £'000s	**109,111**

Confirmation of the £16.697m identified above in relation to changes in the additional 2025/26 employers NI charges was confirmed on July 7th.

PUBLIC SECTOR PAYMENT PERFORMANCE (TABLE H)

The UHB's public sector payment compliance performance is above the 30 day target of 95%. Performance for the month to the end of June was 95.8%.

Performance against the 30 day target for NHS invoices was 81.20%.

CAPITAL RESOURCE LIMIT, IN YEAR SCHEMES & DISPOSALS (TABLES I, J, K & Q)

Of the UHB's approved Capital Resource Limit, 6% has been expended to date.

All schemes are expected to broadly deliver in year in line with forecast.

Discretionary Mental Health projects are being reviewed and will be updated within the discretionary allocation as approved. As the balances of discretionary is assumed to be utilised by the estates programme. This allocation will decrease in line with agreed Mental projects allocation to ensure we stay within our resource limit.

Planned expenditure for the year reflects the CRL received from Welsh Government dated 12th May 2025 - £33.690m.

AGED WELSH NHS DEBTORS (TABLE M)

On the 30th of June 2025 there were no invoices raised by the UHB against other Welsh NHS organisations which were outstanding for more than 17 weeks.

GMS & DENTAL (TABLES N & O)

GMS and Dental expenditure are reported on tables N & O.

IFRS 16 (TABLE Q)

Lease costs, Interest, depreciation and dilapidations are reported at table Q.

OTHER ISSUES

The financial information reported in these monitoring returns aligns to the financial details included within Finance Committee and Board papers. These monitoring returns will be taken to the next available meeting of the Finance Committee for information.

CONCLUSION

The UHB submitted a draft financial plan at the end of March 2025 which included a forecast deficit of £58.200m. Progress in the identification of savings provided the UHB with sufficient assurance to increase planned savings delivery by a further £2m which in turn reduced the forecast deficit position to £56.2 million for 2025/26 at month 3.

The UHB is committed to achieving in year and recurrent financial balance as soon as possible. The UHB currently has a draft financial plan for 2025-26 which aims to deliver financial stability and ensure that the underlying position is maintained. The plan includes a revised savings target of £32.0m.

- the reported year to date position is an overspend of £15.216m and the forecast deficit of £56.2m.
- the month 3 operational overspend against plan is £0.315m and in addition there is year to date £0.844m savings deficit
- £28.624m (89.5%) of green and amber schemes are identified at Month 3 against the £32m target.
- Delivery of the forecast is also predicated on the confirmation of all expected income streams.

…….
SUZANNE RANKIN
CHIEF EXECUTIVE

11th July 2025

…….
CATHERINE PHILLIPS
EXECUTIVE DIRECTOR OF FINANCE

11th July 2025

Cardiff & Vale ULHB **Period : Jun 25**

Table A - Movement of Opening Financial Plan to Forecast Outturn

This Table is currently showing 0 errors

Line 12 should reflect the corresponding amounts included within the latest IMTP/AOP submission to WG
Lines 1 - 12 should not be adjusted after Month 1

		In Year Effect	Non Recurring	Recurring	FYE of Recurring
		£'000	£'000	£'000	£'000
1	Underlying Position b/fwd from Previous Year - must agree to M12 MMR (Deficit - Negative Value)	-59,900	0	-59,900	-59,900
2	Cost Pressures (Negative Value)	-51,100	0	-51,100	-51,100
3	Allocation Letter Revenue Funding Uplift / WG RRL / WG Income Uplift	20,297	0	20,297	20,297
4	Other Income Uplift / (Reduction)	2,471	0	2,471	2,471
5	RRL Profile - phasing only (in-year effect should total nil /Column C)	0	0	0	0
6	Planned (Finalised) Green and Amber Savings Plan	22,185	7,272	14,912	20,891
7	Planned (Finalised) Net Income Generation	2,063	418	1,645	2,150
8	Planned Profit / (Loss) on Disposal of Assets	0	0	0	0
9	Planned Release of Uncommitted Contingencies & Reserves (Positive Value)	0	0		
10		0	0		
11	Red, Pipeline and Planning Assumption Savings still to be finalised at Month 1	7,751	0	7,751	8,959
12	**Opening IMTP / Annual Operating Plan**	**-56,233**	**7,690**	**-63,924**	**-56,232**
13	Reversal of Red, Pipeline and Planning Assumption Savings still to be finalised at Month 1	-7,751	0	-7,751	-8,959
14	Additional In Year & Movement from Planned Profit / (Loss) on Disposal of Assets	0	0		
15	Other Movement in Month 1 Planned & In Year Net Income Generation	120	35	85	155
16	Other Movement in Month 1 Planned Savings - (Underachievement) / Overachievement	-1,537	83	-1,620	-1,325
17	Additional In Year Identified Savings - Forecast	5,319	3,491	1,828	2,177
18	Variance to Planned RRL	-1	-1		
19	Additional In Year & Movement in Planned Welsh Government Funding & Other Income (Positive Value - additional)	-6,255	0	-6,255	-6,255
20	In Year Accountancy Gains	474	474	0	0
21	Unplanned Spend Reductions	8,194	0	8,194	8,194
22	Unplanned Cost Pressures	-2,252	0	-2,252	-2,252
23	Planned Mitigations Yet To Be Finalised	3,377	0	3,377	3,377
24	Unplanned Additional Required Mitigations Yet To Be Finalised	313	0	313	313
25	Other	0	0	0	0
26	Planned Expenditure - Timing, Profiling and Confirmation	0	0	0	0
27		0	0		
28		0	0		
29		0	0		
30		0	0		
31		0	0		
32		0	0		
33		0	0		
34		0	0		
35	**Forecast Outturn (- Deficit / + Surplus)**	**-56,233**	**11,772**	**-68,005**	**-60,807**

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	In Year Effect
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	-4,992	-4,992	-4,992	-4,992	-4,992	-4,992	-4,992	-4,992	-4,992	-4,992	-4,992	-4,992	-14,975	-59,900
2	-4,258	-4,258	-4,258	-4,258	-4,258	-4,258	-4,258	-4,258	-4,258	-4,258	-4,258	-4,258	-12,775	-51,100
3	1,691	1,691	1,691	1,691	1,691	1,691	1,691	1,691	1,691	1,691	1,691	1,691	5,074	20,297
4	206	206	206	206	206	206	206	206	206	206	206	206	618	2,471
5	1,432	853	391	14	135	39	-396	-266	-367	-435	-422	-977	2,676	0
6	1,014	1,053	1,453	1,773	1,667	1,748	2,172	2,027	2,144	2,197	2,198	2,738	3,520	22,185
7	54	71	133	190	175	190	201	216	201	216	201	216	258	2,063
8													0	0
9													0	0
10													0	0
11		523	1,023	689	689	689	689	689	689	689	689	689	1,546	7,751
12	**-4,853**	**-4,853**	**-4,353**	**-4,686**	**-4,686**	**-4,686**	**-4,686**	**-4,686**	**-4,686**	**-4,686**	**-4,686**	**-4,687**	**-14,058**	**-56,233**
13	0	-523	-1,023	-689	-689	-689	-689	-689	-689	-689	-689	-689	-1,546	-7,751
14													0	0
15	0	8	4	-30	5	5	5	5	5	5	5	105	13	120
16	0	0	-204	-131	-148	-131	-158	-158	-141	-159	-159	-147	-204	-1,537
17	0	259	650	1,521	334	371	361	361	357	360	360	385	908	5,319
18			-489	-951	218	163	201	201	185	202	202	65	-489	-1
19	2,589	3,002	-7,155	-521	-521	-521	-521	-521	-521	-521	-521	-521	-1,564	-6,255
20	0	0	474	0	0	0	0	0	0	0	0	0	474	474
21	189	3,015	296	521	521	522	521	521	523	521	521	521	3,500	8,194
22	0	-2,133	-117	0	0	0	0	0	0	0	0	0	-2,250	-2,252
23	0	523	-523	375	375	375	375	375	375	375	375	375	0	3,377
24	0	0	0	35	35	35	35	35	35	35	35	35	0	313
25	0	2,066	-2,067	0	0	0	0	0	0	0	0	0	0	0
26	-4,021	-7,167	11,189										0	0
27													0	0
28													0	0
29													0	0
30													0	0
31													0	0
32													0	0
33													0	0
34													0	0
35	**-6,096**	**-5,803**	**-3,317**	**-4,558**	**-4,557**	**-4,557**	**-4,557**	**-4,557**	**-4,558**	**-4,557**	**-4,557**	**-4,558**	**-15,216**	**-56,233**

Cardiff & Vale ULHB

Period : Jun 25

Table C - Identified Expenditure Savings Schemes (Excludes Income Generation & Accountancy Gains)

This Table is currently showing 0 errors

			1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %age of YTD*	Green	Amber	non recurring	recurring	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	Pay	Budget/Plan	379	480	577	639	827	812	890	892	1,122	1,161	1,162	1,162	1,436	10,103		0	3,335			
2		Actual/F'cast	379	556	814	806	905	877	926	928	1,154	1,196	1,197	1,197	1,749	10,937	15.99%	8,089	2,848	3,102	7,835	12,663
3		Variance	0	76	237	168	79	65	36	36	32	35	35	35	312	834	*21.74%*	8,089	-487			
4	Non-Pay	Budget/Plan	437	342	558	766	471	514	795	648	535	535	535	1,075	1,337	7,211		6,075	1,136			
5		Actual/F'cast	437	506	806	1,369	561	621	894	747	651	634	634	1,211	1,749	9,072	19.27%	8,345	727	5,863	3,209	3,902
6		Variance	0	164	247	603	90	107	99	99	116	99	99	136	412	1,861	*30.79%*	2,270	-409			
7	Primary Care - Drugs & Appliances	Budget/Plan	73	73	73	87	87	87	97	97	97	111	111	111	218	1,107		1,047	60			
8		Actual/F'cast	73	73	73	687	87	87	97	97	97	111	111	111	218	1,707	12.80%	1,647	60	640	1,067	1,252
9		Variance	0	0	0	600	0	0	0	0	0	0	0	0	0	600	*0.00%*	600	0			
10	Secondary Care Drugs	Budget/Plan	49	82	85	85	85	85	87	87	87	87	87	87	216	992		982	10			
11		Actual/F'cast	49	100	103	103	103	152	154	154	154	154	154	154	252	1,536	16.41%	1,182	354	301	1,235	1,274
12		Variance	0	18	18	18	18	67	67	67	67	67	67	67	36	544	*16.86%*	200	344			
13	CHC/FNC	Budget/Plan	59	59	142	170	170	220	273	273	273	273	273	273	260	2,458		2,408	50			
14		Actual/F'cast	59	59	86	170	170	220	273	273	273	273	273	273	204	2,402	8.50%	2,352	50	940	1,462	2,326
15		Variance	0	0	(56)	0	0	0	0	0	0	0	0	0	(56)	(56)	*(21.58%)*	-56	0			
16	Primary Care Contractor	Budget/Plan	0	0	0	9	10	12	12	12	12	12	12	12	0	103		103	0			
17		Actual/F'cast	0	0	0	9	10	12	12	12	12	12	12	12	0	103	0.00%	103	0	0	103	116
18		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
19	Healthcare Services Provided by Other Healthboards	Budget/Plan	3	3	3	3	3	3	3	3	3	3	3	3	8	30		30	0			
20		Actual/F'cast	3	3	3	3	3	3	3	3	3	3	3	3	8	30	25.00%	30	0	0	30	30
21		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	*0.00%*	0	0			
22	Non-healthcare Services Provided by Other Healthboards	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
23		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
24		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
25	Other Private & Voluntary Sector	Budget/Plan	15	15	15	15	15	15	15	15	15	15	15	15	45	180		180	0			
26		Actual/F'cast	15	15	15	15	15	15	15	15	15	15	15	15	45	180	25.00%	180	0	0	180	180
27		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	*0.00%*	0	0			
28	Joint Financing & Other	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
29		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
30		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
34	Total	Budget/Plan	1,014	1,053	1,453	1,773	1,667	1,748	2,172	2,027	2,144	2,197	2,198	2,738	3,520	22,185		10,825	0			
35		Actual/F'cast	1,014	1,311	1,899	3,162	1,854	1,987	2,374	2,230	2,360	2,399	2,400	2,977	4,225	25,966	25.00%	21,928	4,039	10,846	15,120	21,743
36		Variance	0	258	446	1,389	186	239	203	203	216	202	201	238	704	3,782	*0.00%*	11,103	4,039			

37	Variance in month	0.00%	24.52%	30.69%	78.34%	11.18%	13.69%	9.33%	9.99%	10.08%	9.19%	9.17%	8.71%	20.00%	
38	In month achievement against FY forecast	3.91%	5.05%	7.31%	12.18%	7.14%	7.65%	9.14%	8.59%	9.09%	9.24%	9.24%	11.46%		

Regan, Nikki
17/09/2025 08:38:34

Cardiff & Vale ULHB **Period : Jun 25**

Table C1- Savings Schemes Pay Analysis

		Month	1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD	Full-year forecast	Assessment Green £'000	Assessment Amber £'000	Full In-Year forecast non recurring £'000	Full In-Year forecast recurring £'000	Full-Year Effect of Recurring Savings
1		Budget/Plan	205	240	298	343	531	533	612	614	843	882	883	883	743	6,867	0	3,335			
2	Pay - General & Substantive	Actual/F'cast	205	315	569	551	635	624	673	675	901	943	944	944	1,090	7,978	5,130	2,848	1,620	6,359	10,575
3		Variance	0	76	271	209	104	91	61	61	58	61	60	60	347	1,111	5130.282894	(487)			
4		Budget/Plan	141	207	246	262	262	245	245	245	245	245	245	245	594	2,836	0	0			
5	Pay - Variable	Actual/F'cast	141	207	211	222	238	220	220	220	220	220	220	220	559	2,559	2,559	0	1,082	1,476	2,088
6		Variance	0	0	(34)	(41)	(25)	(25)	(25)	(25)	(25)	(25)	(25)	(25)	(34)	(278)	2,559	0			
7		Budget/Plan	33	33	33	33	33	33	33	33	33	33	33	33	100	400	0	0			
8	Pay - Agency	Actual/F'cast	33	33	33	33	33	33	33	33	33	33	33	33	100	400	400	0	400	0	0
9		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	400	0			
10		Budget/Plan	379	480	577	639	827	812	890	892	1,122	1,161	1,162	1,162	1,436	10,103	0	3,335			
11	Total	Actual/F'cast	379	556	814	806	905	877	926	928	1,154	1,196	1,197	1,197	1,749	10,937	8,089	2,848	3,102	7,835	12,663
12		Variance	0	76	237	168	79	65	36	36	32	35	35	35	312	834	8,089	(487)			

Table C2- V&S Saving Categories

		Month	1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD	Full-year forecast
1		Budget/Plan	374	474	572	633	821	806	885	887	1,116	1,155	1,157	1,157	1,420	10,038
2	Workforce	Actual/F'cast	374	550	809	801	900	872	921	923	1,149	1,191	1,192	1,192	1,733	10,872
3		Variance	0	76	237	168	79	65	36	36	32	35	35	35	312	834
4		Budget/Plan	127	140	144	158	158	158	170	170	170	184	184	184	411	1,946
5	Medicines Management	Actual/F'cast	127	158	162	783	183	232	244	244	244	258	258	258	447	3,148
6		Variance	0	18	18	625	25	74	74	74	74	74	74	74	36	1,202
7		Budget/Plan	454	379	571	778	484	527	807	660	547	547	547	1,087	1,404	7,389
8	Procurement & Non-pay	Actual/F'cast	454	544	818	1,375	567	627	900	753	657	640	640	1,217	1,816	9,192
9		Variance	0	164	247	597	83	100	93	93	110	93	93	130	412	1,802
10		Budget/Plan	59	59	142	170	170	220	273	273	273	273	273	273	260	2,458
11	CHC	Actual/F'cast	59	59	86	170	170	220	273	273	273	273	273	273	204	2,402
12		Variance	0	0	(56)	0	0	0	0	0	0	0	0	0	(56)	(56)
13		Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0
14	Pathway	Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0
16		Budget/Plan	0	0	25	25	25	25	25	25	25	25	25	25	25	250
17	Other - Commissioning	Actual/F'cast	0	0	25	25	25	25	25	25	25	25	25	25	25	250
18		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0
19		Budget/Plan	0	0	0	9	10	12	12	12	12	12	12	12	0	103
20	Other - Primary Care	Actual/F'cast	0	0	0	9	10	12	12	12	12	12	12	12	0	103
21		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0
22		Budget/Plan	1,014	1,053	1,453	1,773	1,667	1,748	2,172	2,027	2,144	2,197	2,198	2,738	3,520	22,185
23	Total	Actual/F'cast	1,014	1,311	1,899	3,162	1,854	1,987	2,374	2,230	2,360	2,399	2,400	2,977	4,225	25,966
24		Variance	0	258	446	1,389	186	239	203	203	216	202	201	238	704	3,782

Cardiff & Vale ULHB

Jun 25

Table C3 - Tracker

	£'000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Full-year forecast	Non Recurring	Recurring	FYE Adjustment	Full-year Effect
Savings (Cash Releasing & Cost Avoidance)	Month 1 - Plan	1,014	1,053	1,453	1,773	1,667	1,748	2,172	2,027	2,144	2,197	2,198	2,738	3,520	22,185	7,272	14,912	5,979	20,891
	Month 1 - Actual/Forecast	1,014	1,052	1,250	1,642	1,519	1,616	2,014	1,869	2,003	2,038	2,039	2,591	3,316	20,648	7,355	13,292	6,274	19,566
	Variance	0	(0)	(204)	(131)	(148)	(131)	(158)	(158)	(141)	(159)	(159)	(147)	(204)	(1,537)	83	(1,620)	295	(1,325)
	In Year - Plan	0	259	629	1,513	321	363	365	365	362	365	365	390	887	5,297	3,439	1,858	348	2,206
	In Year - Actual/Forecast	0	259	650	1,521	334	371	361	361	357	360	360	385	908	5,319	3,491	1,828	349	2,177
	Variance	0	0	21	7	13	7	(4)	(4)	(4)	(4)	(4)	(4)	21	22	52	(30)	1	(29)
	Total Plan	1,014	1,311	2,082	3,287	1,988	2,111	2,537	2,393	2,505	2,562	2,563	3,128	4,408	27,481	10,711	16,770	6,327	23,097
	Total Actual/Forecast	1,014	1,311	1,899	3,162	1,854	1,987	2,374	2,230	2,360	2,399	2,400	2,977	4,225	25,966	10,846	15,120	6,623	21,743
	Total Variance	0	(0)	(183)	(124)	(134)	(124)	(163)	(163)	(146)	(163)	(163)	(151)	(183)	(1,515)	135	(1,650)	296	(1,353)
Net Income Generation	Month 1 - Plan	54	71	133	190	175	190	201	216	201	216	201	216	258	2,063	418	1,645	505	2,150
	Month 1 - Actual/Forecast	54	71	83	155	175	190	201	216	201	216	201	216	208	1,978	403	1,575	575	2,150
	Variance	0	0	(50)	(35)	0	0	0	0	0	0	0	0	(50)	(85)	(15)	(70)	70	0
	In Year - Plan	0	8	59	9	9	9	9	9	9	9	9	109	67	250	95	155	1	156
	In Year - Actual/Forecast	0	8	54	5	5	5	5	5	5	5	5	105	63	205	50	155	0	155
	Variance	0	0	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(45)	(45)	0	(1)	(1)
	Total Plan	54	79	192	199	184	199	210	225	210	225	210	325	325	2,313	513	1,800	506	2,306
	Total Actual/Forecast	54	79	138	160	180	195	206	221	206	221	206	321	270	2,183	453	1,730	575	2,305
	Total Variance	0	0	(55)	(40)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(55)	(130)	(60)	(70)	69	(1)
Accountancy Gains	In Year - Plan	0	0	474	0	0	0	0	0	0	0	0	0	474	474	474	0	0	0
	In Year - Actual/Forecast	0	0	474	0	0	0	0	0	0	0	0	0	474	474	474	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	Month 1 - Plan	1,068	1,124	1,586	1,963	1,842	1,938	2,373	2,243	2,345	2,413	2,399	2,954	3,778	24,248	7,690	16,557	6,484	23,041
	Month 1 - Actual/Forecast	1,068	1,123	1,333	1,797	1,694	1,806	2,215	2,085	2,203	2,254	2,240	2,807	3,524	22,626	7,758	14,867	6,849	21,716
	Variance	0	(0)	(254)	(166)	(148)	(131)	(158)	(158)	(141)	(159)	(159)	(147)	(254)	(1,622)	68	(1,690)	365	(1,325)
	In Year - Plan	0	267	1,162	1,523	330	373	374	374	371	374	374	499	1,429	6,020	4,008	2,013	349	2,362
	In Year - Actual/Forecast	0	267	1,178	1,525	339	375	365	365	362	365	365	490	1,445	5,997	4,014	1,983	349	2,332
	Variance	0	0	16	3	9	3	(9)	(9)	(9)	(9)	(9)	(9)	16	(23)	7	(30)	(0)	(30)
	Total Plan	1,068	1,391	2,748	3,486	2,172	2,310	2,747	2,618	2,715	2,787	2,773	3,453	5,207	30,268	11,698	18,570	6,833	25,403
	Total Actual/Forecast	1,068	1,390	2,511	3,322	2,033	2,182	2,580	2,450	2,565	2,619	2,605	3,297	4,969	28,623	11,773	16,850	7,198	24,048
	Total Variance	0	(0)	(238)	(164)	(139)	(129)	(167)	(167)	(150)	(167)	(168)	(156)	(238)	(1,645)	75	(1,720)	365	(1,354)

Summary of Forecast Month 1 & In Year (£000's) - Green & Amber	Cash-Releasing Saving (Pay)	Cash-Releasing Saving (Non Pay)	Cost Avoidance	Savings Total	Income Generation	Accountancy Gains
All Service Areas	3,144	2,326	0	**5,470**	551	474
Scheduled Care	3,426	2,919	0	**6,345**	0	0
Unscheduled Care	87	125	0	**212**	0	0
Mental Health	664	911	0	**1,575**	0	0
Community Services	1,105	410	0	**1,515**	0	0
Primary Care	308	1,489	0	**1,797**	0	0
Commissioned Services - CHC	0	1,676	0	**1,676**	0	0
Commissioned Services - Specialised Services	18	964	0	**982**	615	0
Other Commissioned Services	0	0	0	**0**	0	0
Clinical Support	1,444	1,410	0	**2,854**	337	0
Non Clinical Support	34	0	0	**34**	0	0
Executive / Corporate Areas	681	2,553	0	**3,235**	680	0
Total	**10,912**	**14,782**	**0**	**25,694**	**2,183**	**474**

Report Title:	Monthly Monitoring Return – Month 4			Agenda Item no.		4.1
Meeting:	Finance and Performance Committee		Public	x	Meeting Date:	17.09.25
			Private			
Status:	Assurance	x	Approval		Information	
Lead Executive:	Executive Director of Finance					
Report Author:	Deputy Director of Finance					

Background and current situation:

SITUATION

WHC (2025) 023 - 2025/26 NHS Wales Financial Monitoring Return
Guidance requires the UHB to provide a main Committee of the Board with copy of the monthly Financial Monitoring Return (consisting of the Narrative, Table A and Tables C to C3), to provide the Committee with transparency on the submission made to the Welsh Government.

A copy of the July 2024/25 MMR is attached.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The extracts from the UHBs Monthly Financial Monitoring Return are provided for information and assurance.

- 4.1d CV Financial Monitoring Returns 2025-26 - Month 4
- 4.1e 2024-25 MMR Template - Cardiff Vale UHB Month 4

Recommendation:

The Board/Committee are requested to:

A) **NOTE** the extracts from the UHBs Monthly Financial Monitoring Returns.

Link to Strategic Objectives of Shaping our Future Wellbeing:

https://shapingourfuturewellbeing.com/

1. Putting People First **Click the objective above to view more detail.**		2. Providing Outstanding Quality **Click the objective above to view more detail.**	
3. Delivering in the Right Places **Click the objective above to view more detail.**		4. Acting for the Future **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered									
Prevention		Long term		Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?				
Yes –		No – ***(Please provide reasoning, e.g. not required)***	X	N/A

Impact Assessment:
Risk: No
Safety: No
Financial: Yes
Workforce: No
Legal: No
Reputational: No
Socio Economic: No - ***Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: The Socio-economic Duty: guidance | GOV.WALES***
Equality and Health: No
Decarbonisation: No
Welsh Language: Yes/No

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee:	Date:

THE WELSH GOVERNMENT FINANCIAL COMMENTARY

FINANCIAL POSITION FOR THE FOUR MONTH PERIOD ENDED 31st JULY 2025

INTRODUCTION

The Health Board submitted an initial draft financial plan to the Welsh Government at the end of March 2025.The draft plan incorporated: -

- Brought forward underlying deficit of £59.9m
- 2025/26 Demand and cost growth and unavoidable investments of £51.1m
- Additional Allocations of £20.3m
- Pass-through funding on Long Term Agreements of £2.5m (1.77%)
- A £30.0m Savings Target.

This results in a 2025/26 planning deficit of £58.2m which has now been amended to £56.2m as a result of the additional £2m savings target actioned in year.

The draft plan assumed that:

- The 2025/26 Medical & Dental and Agenda for Change pay awards are fully funded.
- The costs of the Real Living Wage (RLW), being paid to staff directly employed by the UHB, will be funded through the 2025-26 pay award funding in addition to the non recurrent funding for the impact of the policy on the social/third sector.
- The additional £18.8m of costs related to changes to the Employers NI rates will be fully funded.

A summary of the revised draft financial plan submitted is provided in Table 1.

Table 1: 2025/26 Draft Plan

Planning Assumptions	(£m)
Brought Forward Underlying Deficit	59.900
2025/26 Demand/Cost Growth/Improvement	51.100
Draft Deficit	**111.000**
Additional Allocations	(22.768)
Savings Plans	(32.000)
Initial Planned Deficit	**56.233**

This represents the draft financial plan of the Health Board.

The financial monitoring returns have been prepared within the framework of the UHB's revised Draft Financial Plan, which includes a planning deficit of £56.233m for 2025-26. This report details the financial position of the UHB for the period ending 31st July 2025.

A full commentary has been provided to cover the tables requested for the month 4 financial position.

At month 4 the UHB is reporting an overspend of £21.172m, £2.428m off plan.

This is comprised of £1.503m unidentified savings, £0.925m of operational deficit and the planned deficit of £18.744m (4 twelfths of the revised £56.233m 2025/26 planned deficit set out in the UHB's Accountable Officer letter relayed on the 30th of June 2025).

BACKGROUND

The Board noted and submitted a draft financial plan to the Welsh Government at the end of March 2025. Following the submission of the plan, Welsh Government asked the UHB to detail further actions to reduce the forecast deficit of £58.2m. In response, the UHB confirmed that progress in the identification of savings provided the UHB with sufficient assurance to increase planned savings delivery by £2m which in turn has reduced the forecast 2025/26 deficit position to £56.2 million.

MOVEMENT OF OPENING FINANCIAL PLAN TO FORECAST OUTTURN and UNDERLYING POSITION (TABLE A & A1)

Table A sets out the draft financial plan and latest position at month 4 for which the following should be noted:

- The UHB's initial £30.0m 2025/26 savings target is reported on lines 6,7 & 11. The forecast achievement of the further target of £2.0m is also reported on lines 6,7 & 11 with the further £2m schemes required to meet the £32m target being reported on line 24.
- It is assumed that LTA inflation of £2.471m (1.77%) will be passed to the UHB from other Health Boards (line 4).
- The bought forward underlying deficit is £59.9m as outlined in the draft financial plan.

The identification and delivery of the £32.0m recurrent savings target is key to delivery of the planned in year and underlying position.

OVERVIEW OF KEY RISKS & OPPORTUNITIES (TABLE A2)

Table A2 reflects a review of the risks identified in the financial plan and these will continue to be reviewed on a monthly basis. In addition, the table also reflects the following risks

- Managing the shortfall in funding for the additional employer changes arising from changes in pay and employers NI rates £1.558m
- The potential further Risk Pool liability of £7.530m arising from the indicative apportionments of the £42m increased risk associated with the WRP claims that are forecast to settle in 2025/26.
- The potential additional cost of band 2 & 3 pay costs has been reviewed and updated to £6.997m in month.
- The application of the Six Goals funding. The UHB continues to work with the National Programme Director Office for Six Goals for UEC Programme to eliminate the risk relating to the use of this funding
- The potential opportunity arising from the Microsoft DHCW Review is noted.

ACTUAL YEAR TO DATE (TABLE B AND B2)

Table B confirms the year to date deficit of £21.172m and reflects the analysis contained in the annual operating plan in Table A. The deficit of £21.172m for the year to date as shown in Table 2.

Table 2: Summary Financial Position for the period ended 31st July 2025

	Plan PTD (£m)	PTD (£m)	PTD Variance to Plan (£m)	Plan YTD (£m)	YTD (£m)	YTD Variance to Plan (£m)
Draft Plan	8,489	8,489	0	27,840	27,840	0
Quality Efficiency Improvement Plans - Savings	(3,805)	(3,146)	659	(9,096)	(7,593)	1,503
Operational Variance	0	612	612	0	925	925
Clinical/Service Board Variance	**4,684**	**5,955**	**1,271**	**18,744**	**21,172**	**2,428**

The month 4 deficit of £21.172m comprised of the following:

- £18.744m planned deficit
- £1.503m unachieved CRP gap
- £0.925m adverse operational variance against plan.

The £56.2m forecast deficit is profiled flat.

It is anticipated that the unachieved CRP gap and operational pressures at month 4 will be recovered as the year progresses and that the UHB will deliver its planned deficit position of £56.200m.

Table 3:Operational Pressures for the period ended 31st July 2025

Operational Pressure	Operational Variance YTD £'000s	Operational Variance Forecast £'000s
JCC Forecast Outurn Growth	133	1,036
Employers NI (ENIC) Funding Gap	515	1,558
Specialist Services Activity Related Underperformance	1,480	0
Out Of Area Placements (OOA)	1,016	1,003
Prescribing Growth	(446)	(955)
Pay Vacancies	(1,773)	(2,642)
Sub-Total Surplus/Deficit	**925**	**0**

Further detail in relation to table 3 is provided below:

- Commissioning. The risk against the JCC forecast outturn is recognized at an annual cost of £1.037m
- The Employers NI Gap has been amended in month to reflect the additional cost in relation to recharges to HEIW where 2025/26 recharges will be based on 2024/25 rates of NI funding.
- Specialist services underperformance. There is reported underperformance in cardiac services where the UHB is reviewing activity against the previous year's delivery.

Underperformance against out of area critical care capacity is expected to regress to the mean as the year progresses

- Mental Health OOA - The Clinical Board is reviewing Bed Flow daily and further investigating options to reduce the volume and cost of OOA.
- Growth in GP prescribing volumes is less than forecast for the year to date and will continue to be reviewed as further prescribing data becomes available.
- Pay – vacancies in Estates, Executive functions & PCIC along with enhanced scrutiny around variable pay are partially offset pressures against medical staff where additional costs are being incurred to cover vacancies, Less Than Full Time (LTFT) posts and sickness.

Executive Performance Reviews with the UHBs Clinical Boards focus on ensuring that both planning and operational pressures are identified and managed as they arise. In addition, the UHB remains focussed on tracking delivery against its savings plans whilst identifying opportunities for further improvements through weekly Senior Leadership Team meetings and dedicated financial summits. that in turn will de-risk the draft financial plan.

The UHB financial plan has been established at a Clinical Board level with each Board working towards an agreed control total based on the following:

- Underlying Deficit b/f to 2025-26
- Cost Growth
- Demand/Volume Growth
- Commissioning pressures
- Allocation of 1.77% Welsh Government Uplift against assessed Growth and Pressures
- Quality Improvement Programmes (savings)

A number of operational pressures have continued into month 4, which in turn have been partly offset by operational underspends across service areas as summarized below:

Table B2 – Movements from Opening Expenditure Plan

Following the submission of the draft financial plan, the UHB has reviewed and reassessed its resource limit assumptions as oulined in Table 4 below. The main change in assumptions relates to the June 2025 non cash return for depreciation and impairments. In addition there are £16.7m additional costs arising from changes in Employer NI rates and threshold values alongside confirmation of DPIF prgramme funding and the impact of the Real Living Wage increase on the cost of UHB employees at bands 2 & 3

Table 4 – Additional Resource Limit Assumptions

Additional Resource Limit Allocations	£'000s
25_26 NIER Additional 1.2 Percent And Threshold Change	16,697
All Wales International Recruitment	7
Allocation Uplift - Invest 2 Save	0
AME Non Cash Depreciation - IFRS 16 Leases (Peppercorn)	(8)
AME Non Cash Depreciation - Donated Assets	(168)
AME Non Cash Depreciation - Impairment	30,341
ARRP	109
AWTTC Voluntary Scheme For Branded Medicines Pricing, Access And Growth (VPAG) I	600
CAMHS In-Reach Funding	622
Children's Speech, Language And Communication (SLC)	34
Community Pharmacy Pilot Injectable LARC For Contraceptive Purpose	10
Consultant Allied Health Professional For Dementia	30
Consultant Clinical Excellence Award / Consultant Impact Award	347
Decabonisation Secondment FB	28
DEL Non Cash Depreciation - Baseline Surplus / Shortfall	(3,376)
DEL Non Cash Depreciation - IFRS 16 Leases	3,070
DEL Non Cash Depreciation - Accelerated	1,979
Dementia Action Plan	100
Digital Eyecare Programme	(362)
DoLS / MCA / Advocacy (MH)	256
DPIF	4,082
DPIF All Wales Pharmacy (Eps Go Live)	57
ESMCP Control Room	116
ESMCP WAST Resources	38
Climate-Focussed Spread And Scale Academy	52
Funding For Prevention And Early Years	43
Genomics (C&V / JCC	323
GP IM&T Refresh Programme	0
Individual Placement & Support In Primary Care	440
Invest To Save - Welsh Government Energy Service	(347)
JCC English Contracting Income	(309)
Learning Disability Policy _Additional Funding 2025_26	110
MOD St Athan Funding LAZURITE team additional reception site for EPs	(282)
Non Cash Limited Funding	1,693
Neighbourhood District Nursing	137
Neurodivergence Improvement Programme	660
New Medical Training Posts 2017 to 2024	283
Pay award funding 2024-25	(5,069)
Short Breaks For Carers	172
Neurodivergence Improvement Programme Funding (Ndip) Rpb	(502)
Planned Care Additional Funding 2025-26 - Phase 3 Outpatients	193
Planned Care Transformation Fund	671
Real Living Wage (RLW) Social Care	(1,568)
Real Living Wage RLW 2025_26	3,344
Removal of Donated Assets / Government Grant Receipts	(521)
Removal of IFRS-16 Leases (Revenue)	(160)
RSV Vaccination Programme	246
RTT Waiting Times _ Q1 Plans	2,783
Save A Life Cymru (JCC) Quarters 2_4	61
Secondment FB Work On Medical Gases Activities	4
Support Staff Costs - All Wales Pharmacogenetics Lead Post	96
WAST Mobile Data Vehicle Solutions	108
Women's Health - Pathfinder Establishment (Women's Health Hubs)	300
Total Movement in assumed Resource Limit following MDS Submission £'000s	**57,570**

PAY & AGENCY (TABLE B2)

The UHB recorded Agency costs of £0.687m in month. The spike in medical agency relates to the ePMA project where specialist recruitment costs have been reported in month. £0.172m of the costs recorded in July related to registered nursing and midwifery and a further £0.124m to additional clinical services.

Agency Costs have reduced from an monthly average of £0.507m in 2024/25 to £0.422m in 2025/26 as a result of enabling actions taken to manage down UHB agency usage.

Forecast agency spend has been reviewed to exclude expenditure on A&C, ACS and Estates categories from September onwards.

Savings Programme 2025-26 (TABLE C, C1, C2, C3 & C4)

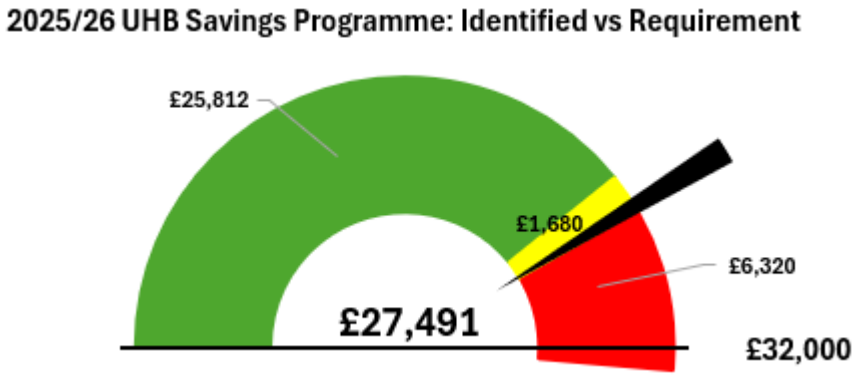
Following a comprehensive review of all schemes at month 4 the forecast delivery against amber and green schemes has been reassessed and amended to £27.491m which is 85.9% of the £32m savings target. In light of this the UHB has pressed all parts of the organisation to accelerate the identification and implementation of further schemes.

The UHB acknowledges that a deadline of the 11 September 2025 (Month 5 MMR submission date) has been assigned to the Health Board to finalise the 'Planned Savings' gap and that all schemes must meet the ‘Green’ criteria by that date. The UHB is working collectively to agree urgent actions that will achieve this requirement.

Red schemes of £6.320m are also identified and continue to be reviewed for progression to Green/Amber where possible.

There is a reported gap of £4.509m against the £32.0m savings target. Red schemes are excluded in accordance with the instruction from Welsh Government that red schemes are not included in the Monthly Monitoring Returns savings tables. Graph 1 below outlines progress in the identification of Savings Schemes.

Graph 1 – Progress in the Identification of Savings Schemes



INCOME/EXPENDITURE ASSUMPTIONS (TABLE D)

NHS organisations were expected to have concluded discussions and signed contracts (Long Term Agreements and Service Level Agreements) between each other by June 12th, 2025.

The UHB has completed discussions to agree contract activity and financial values for all Long Term Agreements (LTA) and Service Level Agreements with other Welsh NHS LHBs

INCOME ASSUMPTIONS 2025/26 (TABLE E)

Table E outlines the UHB's 2025/26 resource limit.

Similar to practice in previous years, the UHB reported position continues to exclude recurrent expenditure which has arisen following a change in the accounting treatment of UHB PFI schemes under International Financial Reporting Standards (IFRS). The UHB is assuming that Welsh Government will continue to provide resource cover for this cost, which was assessed at £0.222m in the previous financial year.

The UHBs confirmed Revenue Resource Limit as of July 31st, 2025, was £1,360m with a further £128.2m of assumed allocations as detailed at Table 5 below:

Table 5 – Unconfirmed Resource Limit Allocations as of 31st July 2025

Unconfirmed Resource Limit Allocations as of 31st July 2025	£'000s
Depreciation, Impairments & IFRS 12	34,401
Pay award funding 2024-25- including Bank Staff	64,482
Pay Award Funding Real Living Wage RLW 2025_26 - Additional Employer Costs	3,344
Vertex (JCC)	6,894
Real Living Wage (Care Homes)	4,612
Urgent & Emergency Care Fund	2,960
RTT Waiting Times _ Q1 Plans	2,783
Consultant Clinical Excellence Award / Consultant Impact Award	2,143
New Medical Training Posts 2017 to 2024	2,019
ATMPs (JCC)	1,944
Dementia Action Plan	2,019
GP IM&T Refresh Programme	1,225
Prevention And Early Years AHW - Early Prevention	881
Neurodivergence Improvement Programme	793
AWTCC Voluntary Scheme For Branded Medicines Pricing, Access And Growth (VPAG) Investmer	600
Planned Care Transformation Fund	565
A2A Sanctuary	503
Integration And Rebalancing Capital Fund (IRCF)	450
Individual Placement & Support In Primary Care	440
Genomics (C&V / JCC	323
Women's Health - Pathfinder Establishment (Women's Health Hubs)	300
Welsh Risk Pool	(5,702)
Other	241
Total Anticipated Funding £'000s	**128,220**

This level of unconfirmed allocation (£128.2m less the £34.4m depreciation funding) will present a cash management risk to the UHB if it remains outstanding into the Autumn period. The risk increases when it is combined with the forecast financial deficit (£56.2m) alongside the requirement of the UHB to fund multi-million pound clinical negligence settlements instructed by the Welsh Risk Pool (WRP). Reimbursement for WRP instructed payments is always received in arrears of payment.

BALANCE SHEET (TABLE F)

The Opening Balances at the beginning of April 25 reflect the closing balances in the 2024/25 Final accounts.

Property, plant & equipment is broadly in line with the start of the year. This is due to capital purchases combined with the impact of monthly depreciation charges.

The increase in the carrying values of Trade and Other receivables is predominantly due to an increase in NHS Prepayments and Receivables netted down by a reduction in the WRP quantum values.

The increase in the carrying value of Trade and Other Payables is predominately due to an increase in NHS payables and Accruals and the timing of the clearance of payments made.

The reduction in the carrying value of Provisions is a result of a reduction in Clinical negligence provisions.

The forecast balance sheet reflects the UHB's latest non-cash estimates and its anticipated capital funding.

MONTHLY CASHFLOW FORECAST (TABLE G)

The closing cash balance at the end of July, was £4.289m.

In due course, the UHB expects to seek Finance Committee and Board approval to request £56.2m strategic cash support from Welsh Government to cover the cash shortfall arising from the forecast deficit.

The UHB will continue to review the movement in its working balances cash for Capital and Revenue as the year progresses. Estimates of any associated cash support required will be included in table E.

PUBLIC SECTOR PAYMENT PERFORMANCE (TABLE H)

The UHB's public sector payment compliance performance is above the 30 day target of 95%. Performance for the month to the end of July was 95.8%.

Performance against the 30 day target for NHS invoices was 81.90%.

CAPITAL RESOURCE LIMIT, IN YEAR SCHEMES & DISPOSALS (TABLES I, J, K & Q)

Of the UHB's approved Capital Resource Limit, 9% has been expended to date.

All schemes are expected to broadly deliver in year in line with forecast.

Discretionary Mental Health projects are being reviewed and will be updated within the discretionary allocation as approved. As the balances of discretionary is assumed to be utilised by the estates programme. This allocation will decrease in line with the agreed Mental Health projects allocation to ensure the UHB stays within its resource limit.

Planned expenditure for the year reflects the CRL received from Welsh Government dated 30th July 2025 - £34.322m.

AGED WELSH NHS DEBTORS (TABLE M)

On the 31st of July 2025 there were no invoices raised by the UHB against other Welsh NHS organisations which were outstanding for more than 17 weeks.

GMS & DENTAL (TABLES N & O)

GMS and Dental expenditure at quarter 1 are reported on tables N & O.

IFRS 16 (TABLE Q)

Lease costs, Interest, depreciation and dilapidations are reported at table Q.

The CAME dilapidations figure of £0.555m in table Q comprises the following reflects the figure included in the July 2025 IFRS16 return.

OTHER ISSUES

The financial information reported in these monitoring returns aligns to the financial details included within Finance Committee and Board papers. These monitoring returns will be taken to the next available meeting of the Finance Committee for information.

CONCLUSION

The UHB submitted a draft financial plan at the end of March 2025 which included a forecast deficit of £58.200m. Progress in the identification of savings provided the UHB with sufficient assurance to increase planned savings delivery by a further £2m which in turn reduced the forecast deficit position to £56.2 million for 2025/26 at month 3.

The UHB is committed to achieving in year and recurrent financial balance as soon as possible. The UHB currently has a draft financial plan for 2025-26 which aims to deliver financial stability and ensure that the underlying position is maintained. The plan includes a revised savings target of £32.0m.

- the reported year to date position is an overspend of £21.172m and the forecast deficit of £56.2m.
- the month 4 operational overspend against plan is £0.925m and in addition there is year to date £1.503m savings deficit.
- £27.491m (85.9%) of green and amber schemes are identified at Month 4 against the £32m target.
- Delivery of the forecast is also predicated on the confirmation of all
- expected income streams.

…….
SUZANNE RANKIN
CHIEF EXECUTIVE

13th August 2025

…….
CATHERINE PHILLIPS
EXECUTIVE DIRECTOR OF FINANCE

13th August 2025

Cardiff & Vale ULHB **Period :** **Jul 25**

Table A - Movement of Opening Financial Plan to Forecast Outturn

This Table is currently showing 0 errors

Line 12 should reflect the corresponding amounts included within the latest IMTP/AOP submission to WG
Lines 1 - 12 should not be adjusted after Month 1

		In Year Effect	Non Recurring	Recurring	FYE of Recurring
		£'000	£'000	£'000	£'000
1	Underlying Position b/fwd from Previous Year - must agree to M12 MMR (Deficit - Negative Value)	-59,900	0	-59,900	-59,900
2	Cost Pressures (Negative Value)	-51,100	0	-51,100	-51,100
3	Allocation Letter Revenue Funding Uplift / WG RRL / WG Income Uplift	20,297	0	20,297	20,297
4	Other Income Uplift / (Reduction)	2,471	0	2,471	2,471
5	RRL Profile - phasing only (in-year effect should total nil /Column C)	0	0	0	0
6	Planned (Finalised) Green and Amber Savings Plan	22,185	7,272	14,912	20,891
7	Planned (Finalised) Net Income Generation	2,063	418	1,645	2,150
8	Planned Profit / (Loss) on Disposal of Assets	0	0	0	0
9	Planned Release of Uncommitted Contingencies & Reserves (Positive Value)	0	0		
10		0	0		
11	Red, Pipeline and Planning Assumption Savings still to be finalised at Month 1	7,751	0	7,751	8,959
12	**Opening IMTP / Annual Operating Plan**	**-56,233**	**7,690**	**-63,924**	**-56,232**
13	Reversal of Red, Pipeline and Planning Assumption Savings still to be finalised at Month 1	-7,751	0	-7,751	-8,959
14	Additional In Year & Movement from Planned Profit / (Loss) on Disposal of Assets	0	0		
15	Other Movement in Month 1 Planned & In Year Net Income Generation	327	534	-207	5
16	Other Movement in Month 1 Planned Savings - (Underachievement) / Overachievement	-3,440	-411	-3,029	-3,696
17	Additional In Year Identified Savings - Forecast	5,757	3,724	2,033	2,366
18	Variance to Planned RRL	-1	-1		
19	Additional In Year & Movement in Planned Welsh Government Funding & Other Income (Positive Value - additional)	-6,255	0	-6,255	-6,255
20	In Year Accountancy Gains	600	600	0	0
21	Unplanned Spend Reductions	8,983	0	8,983	8,983
22	Unplanned Cost Pressures	-5,077	0	-5,077	-5,077
23	Planned Mitigations Yet To Be Finalised	4,509	0	4,509	4,509
24	Unplanned Additional Required Mitigations Yet To Be Finalised	2,349	0	2,349	2,349
25	Other	0	0	0	0
26	Planned Expenditure - Timing, Profiling and Confirmation	0	0	0	0
27		0	0		
28		0	0		
29		0	0		
30		0	0		
31		0	0		
32		0	0		
33		0	0		
34		0	0		
35	**Forecast Outturn (- Deficit / + Surplus)**	**-56,233**	**12,136**	**-68,368**	**-62,007**

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	In Year Effect
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	-4,992	-4,992	-4,992	-4,992	-4,992	-4,992	-4,992	-4,992	-4,992	-4,992	-4,992	-4,992	-19,967	-59,900
2	-4,258	-4,258	-4,258	-4,258	-4,258	-4,258	-4,258	-4,258	-4,258	-4,258	-4,258	-4,258	-17,033	-51,100
3	1,691	1,691	1,691	1,691	1,691	1,691	1,691	1,691	1,691	1,691	1,691	1,691	6,766	20,297
4	206	206	206	206	206	206	206	206	206	206	206	206	824	2,471
5	1,432	853	391	14	135	39	-396	-266	-367	-435	-422	-977	2,690	0
6	1,014	1,053	1,453	1,773	1,667	1,748	2,172	2,027	2,144	2,197	2,198	2,738	5,294	22,185
7	54	71	133	190	175	190	201	216	201	216	201	216	448	2,063
8													0	0
9													0	0
10													0	0
11		523	1,023	689	689	689	689	689	689	689	689	689	2,235	7,751
12	**-4,853**	**-4,853**	**-4,353**	**-4,686**	**-4,686**	**-4,686**	**-4,686**	**-4,686**	**-4,686**	**-4,686**	**-4,686**	**-4,687**	**-18,744**	**-56,233**
13	0	-523	-1,023	-689	-689	-689	-689	-689	-689	-689	-689	-689	-2,235	-7,751
14													0	0
15	0	8	4	115	2	-23	-35	-35	-35	0	0	326	128	327
16	0	0	-204	-808	-138	-251	-345	-358	-351	-410	-368	-207	-1,012	-3,440
17	0	259	650	1,609	477	403	389	383	379	383	383	443	2,518	5,757
18			-489	-1,012	-27	185	305	324	320	342	300	-249	-1,500	-1
19	2,589	3,002	-7,155	-521	-521	-521	-521	-521	-521	-521	-521	-521	-2,085	-6,255
20	0	0	474	126	0	0	0	0	0	0	0	0	600	600
21	189	3,015	296	804	585	585	585	585	585	585	585	585	4,304	8,983
22	0	-2,133	-117	-894	-242	-242	-242	-242	-242	-242	-242	-242	-3,144	-5,077
23	0	523	-523	0	564	564	564	564	564	564	564	564	0	4,509
24	0	0	0	0	294	294	294	294	294	294	294	294	0	2,349
25	0	2,066	-2,067	0	0	0	0	0	0	0	0	0	0	0
26	-4,021	-7,167	11,189										0	0
27													0	0
28													0	0
29													0	0
30													0	0
31													0	0
32													0	0
33													0	0
34													0	0
35	**-6,096**	**-5,803**	**-3,317**	**-5,956**	**-4,382**	**-4,382**	**-4,383**	**-4,383**	**-4,382**	**-4,382**	**-4,383**	**-4,383**	**-21,172**	**-56,233**

Cardiff & Vale ULHB

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Table C - Identified Expenditure Savings Schemes (Excludes Income Generation & Accountancy Gains)

This Table is currently showing 0 errors

			1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %age of YTD*	Green	Amber	non recurring	recurring	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	Pay	Budget/Plan	379	480	577	639	827	812	890	892	1,122	1,161	1,162	1,162	2,075	10,103		0	923			
2		Actual/F'cast	379	556	814	799	1,026	870	914	896	1,113	1,112	1,156	1,177	2,548	10,811	23.57%	10,360	452	3,219	7,592	11,442
3		Variance	0	76	237	161	199	58	24	4	(9)	(48)	(7)	14	473	708	*22.79%*	10,360	-471			
4	Non-Pay	Budget/Plan	437	342	558	766	471	514	795	648	535	535	535	1,075	2,103	7,211		6,566	645			
5		Actual/F'cast	437	506	806	977	690	599	880	734	638	621	621	1,347	2,725	8,854	30.78%	8,537	318	5,433	3,421	4,127
6		Variance	0	164	247	211	218	85	86	86	103	86	86	272	623	1,643	*29.60%*	1,970	-328			
7	Primary Care - Drugs & Appliances	Budget/Plan	73	73	73	87	87	87	97	97	97	111	111	111	306	1,107		1,047	60			
8		Actual/F'cast	73	73	73	687	87	87	97	97	97	111	111	111	906	1,707	53.07%	1,647	60	640	1,067	1,252
9		Variance	0	0	0	600	0	0	0	0	0	0	0	0	600	600	*196.20%*	600	0			
10	Secondary Care Drugs	Budget/Plan	49	82	85	85	85	85	87	87	87	87	87	87	301	992		982	10			
11		Actual/F'cast	49	100	103	108	110	159	161	161	161	161	161	175	360	1,608	22.38%	1,240	368	301	1,307	1,288
12		Variance	0	18	18	23	25	74	74	74	74	74	74	88	59	616	*19.59%*	258	358			
13	CHC/FNC	Budget/Plan	59	59	142	170	170	220	273	273	273	273	273	273	430	2,458		2,408	50			
14		Actual/F'cast	59	59	86	(23)	66	154	126	126	126	126	126	126	181	1,156	15.70%	1,106	50	940	216	1,126
15		Variance	0	0	(56)	(192)	(104)	(66)	(147)	(147)	(147)	(147)	(147)	(147)	(249)	(1,302)	*(57.81%)*	-1,302	0			
16	Primary Care Contractor	Budget/Plan	0	0	0	9	10	12	12	12	12	12	12	12	9	103		103	0			
17		Actual/F'cast	0	0	0	9	10	12	21	21	21	21	21	21	9	155	5.73%	155	0	52	103	116
18		Variance	0	0	0	0	0	0	9	9	9	9	9	9	0	52	*0.00%*	52	0			
19	Healthcare Services Provided by Other Healthboards	Budget/Plan	3	3	3	3	3	3	3	3	3	3	3	3	10	30		30	0			
20		Actual/F'cast	3	3	3	3	3	3	3	3	3	3	3	3	10	30	33.33%	30	0	0	30	30
21		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	*0.00%*	0	0			
22	Non-healthcare Services Provided by Other Healthboards	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
23		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
24		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
25	Other Private & Voluntary Sector	Budget/Plan	15	15	15	15	15	15	15	15	15	15	15	15	60	180		180	0			
26		Actual/F'cast	15	15	15	15	15	15	15	15	15	15	15	15	60	180	33.33%	180	0	0	180	180
27		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	*0.00%*	0	0			
28	Joint Financing & Other	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
29		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
30		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
34	Total	Budget/Plan	1,014	1,053	1,453	1,773	1,667	1,748	2,172	2,027	2,144	2,197	2,198	2,738	5,294	22,185		11,316	0			
35		Actual/F'cast	1,014	1,311	1,899	2,575	2,006	1,900	2,216	2,052	2,173	2,169	2,212	2,973	6,799	24,501	33.33%	23,254	1,247	10,585	13,916	19,561
36		Variance	0	258	446	802	339	152	44	25	29	(27)	14	235	1,506	2,317	*0.00%*	11,938	1,247			
37	Variance in month		0.00%	24.52%	30.69%	45.21%	20.33%	8.68%	2.05%	1.22%	1.35%	(1.25%)	0.65%	8.59%	28.44%							
38	In month achievement against FY forecast		4.14%	5.35%	7.75%	10.51%	8.19%	7.75%	9.05%	8.38%	8.87%	8.85%	9.03%	12.14%								

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Table C1- Savings Schemes Pay Analysis

		Month	1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD	Full-year forecast	Assessment Green £'000	Assessment Amber £'000	Full In-Year forecast non recurring £'000	Full In-Year forecast recurring £'000	Full-Year Effect of Recurring Savings
1		Budget/Plan	314	347	427	488	677	662	740	742	972	1,011	1,012	1,012	1,577	8,403	0	923			
2	Pay - General & Substantive	Actual/F'cast	314	422	668	674	867	711	755	738	954	954	997	1,018	2,079	9,074	8,622	452	1,824	7,249	10,900
3		Variance	0	76	241	186	191	50	15	(5)	(17)	(57)	(15)	6	502	670	8621.77739	(471)			
4		Budget/Plan	32	100	117	117	117	117	117	117	117	117	117	117	365	1,300	0	0			
5	Pay - Variable	Actual/F'cast	32	100	112	92	125	125	125	125	125	125	125	125	336	1,338	1,338	0	995	343	542
6		Variance	0	0	(4)	(25)	8	8	8	8	8	8	8	8	(29)	38	1,338	0			
7		Budget/Plan	33	33	33	33	33	33	33	33	33	33	33	33	133	400	0	0			
8	Pay - Agency	Actual/F'cast	33	33	33	33	33	33	33	33	33	33	33	33	133	400	400	0	400	0	0
9		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	400	0			
10		Budget/Plan	379	480	577	639	827	812	890	892	1,122	1,161	1,162	1,162	2,075	10,103	0	923			
11	Total	Actual/F'cast	379	556	814	799	1,026	870	914	896	1,113	1,112	1,156	1,177	2,548	10,811	10,360	452	3,219	7,592	11,442
12		Variance	0	76	237	161	199	58	24	4	(9)	(48)	(7)	14	473	708	10,360	(471)			

Table C2- V&S Saving Categories

		Month	1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD	Full-year forecast
1		Budget/Plan	379	480	577	639	827	812	890	892	1,122	1,161	1,162	1,162	2,075	10,103
2	Workforce	Actual/F'cast	379	556	814	769	1,026	870	914	896	1,113	1,112	1,156	1,177	2,518	10,781
3		Variance	0	76	237	131	199	58	24	4	(9)	(48)	(7)	14	443	678
4		Budget/Plan	122	134	138	153	153	153	164	164	164	178	178	178	547	1,881
5	Medicines Management	Actual/F'cast	122	153	156	782	184	233	245	245	245	259	259	273	1,213	3,155
6		Variance	0	18	18	629	31	80	80	80	80	80	80	94	665	1,274
7		Budget/Plan	454	379	571	778	484	527	807	660	547	547	547	1,087	2,182	7,389
8	Procurement & Non-pay	Actual/F'cast	454	544	793	1,004	687	597	878	731	635	618	618	1,344	2,795	8,904
9		Variance	0	164	222	226	203	70	71	71	88	71	71	257	613	1,514
10		Budget/Plan	59	59	142	170	170	220	273	273	273	273	273	273	430	2,458
11	CHC	Actual/F'cast	59	59	86	(23)	66	154	126	126	126	126	126	126	181	1,156
12		Variance	0	0	(56)	(192)	(104)	(66)	(147)	(147)	(147)	(147)	(147)	(147)	(249)	(1,302)
13		Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0
14	Pathway	Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0
16		Budget/Plan	0	0	25	25	25	25	25	25	25	25	25	25	50	250
17	Other - Commissioning	Actual/F'cast	0	0	50	33	33	33	33	33	33	33	33	33	83	350
18		Variance	0	0	25	8	8	8	8	8	8	8	8	8	33	100
19		Budget/Plan	0	0	0	9	10	12	12	12	12	12	12	12	9	103
20	Other - Primary Care	Actual/F'cast	0	0	0	9	10	12	21	21	21	21	21	21	9	155
21		Variance	0	0	0	0	0	0	9	9	9	9	9	9	0	52
22		Budget/Plan	1,014	1,053	1,453	1,773	1,667	1,748	2,172	2,027	2,144	2,197	2,198	2,738	5,294	22,185
23	Total	Actual/F'cast	1,014	1,311	1,899	2,575	2,006	1,900	2,216	2,052	2,173	2,169	2,212	2,973	6,799	24,501
24		Variance	0	258	446	802	339	152	44	25	29	(27)	14	235	1,506	2,317

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Table C3 - Tracker

	£'000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Full-year forecast	Non Recurring	Recurring	FYE Adjustment	Full-year Effect
Savings (Cash Releasing & Cost Avoidance)	Month 1 - Plan	1,014	1,053	1,453	1,773	1,667	1,748	2,172	2,027	2,144	2,197	2,198	2,738	5,294	22,185	7,272	14,912	5,979	20,891
	Month 1 - Actual/Forecast	1,014	1,052	1,250	965	1,530	1,497	1,827	1,669	1,793	1,787	1,830	2,531	4,282	18,744	6,861	11,883	5,312	17,195
	Variance	0	(0)	(204)	(808)	(138)	(251)	(345)	(358)	(351)	(410)	(368)	(207)	(1,012)	(3,440)	(411)	(3,029)	(667)	(3,696)
	In Year - Plan	539	444	839	1,490	418	460	456	456	452	490	365	390	3,313	6,799	3,983	2,815	624	3,439
	In Year - Actual/Forecast	0	259	650	1,609	477	403	389	383	379	383	383	443	2,518	5,757	3,724	2,033	333	2,366
	Variance	(539)	(186)	(190)	120	59	(57)	(66)	(72)	(73)	(108)	18	53	(795)	(1,042)	(259)	(782)	(291)	(1,073)
	Total Plan	1,554	1,497	2,292	3,263	2,085	2,208	2,627	2,483	2,596	2,687	2,563	3,128	8,606	28,983	11,256	17,728	6,603	24,330
	Total Actual/Forecast	1,014	1,311	1,899	2,575	2,006	1,900	2,216	2,052	2,173	2,169	2,212	2,973	6,799	24,501	10,585	13,916	5,645	19,561
	Total Variance	(539)	(186)	(393)	(688)	(79)	(308)	(411)	(431)	(423)	(518)	(351)	(155)	(1,807)	(4,482)	(670)	(3,812)	(958)	(4,769)
Net Income Generation	Month 1 - Plan	54	71	133	190	175	190	201	216	201	216	201	216	448	2,063	418	1,645	505	2,150
	Month 1 - Actual/Forecast	54	71	83	72	163	153	151	166	151	201	186	231	280	1,680	397	1,283	717	2,000
	Variance	0	0	(50)	(118)	(13)	(38)	(50)	(50)	(50)	(15)	(15)	15	(168)	(383)	(21)	(362)	212	(150)
	In Year - Plan	102	110	64	133	15	15	15	15	15	211	9	109	408	811	656	155	1	156
	In Year - Actual/Forecast	0	8	54	233	15	15	15	15	15	15	15	311	296	710	555	155	0	155
	Variance	(102)	(102)	(10)	100	(0)	(0)	(0)	(0)	(0)	(197)	5	202	(113)	(102)	(102)	(0)	(1)	(1)
	Total Plan	155	181	198	323	190	205	216	231	216	427	210	325	856	2,875	1,075	1,800	506	2,306
	Total Actual/Forecast	54	79	138	305	177	167	166	181	166	216	201	542	576	2,390	952	1,438	717	2,155
	Total Variance	(102)	(102)	(60)	(18)	(13)	(38)	(50)	(50)	(50)	(212)	(10)	217	(281)	(485)	(123)	(362)	211	(151)
Accountancy Gains	In Year - Plan	0	0	474	0	0	0	0	0	0	0	0	0	474	474	474	0	0	0
	In Year - Actual/Forecast	0	0	474	126	0	0	0	0	0	0	0	0	600	600	600	0	0	0
	Variance	0	0	0	126	0	0	0	0	0	0	0	0	126	126	126	0	0	0
Total	Month 1 - Plan	1,068	1,124	1,586	1,963	1,842	1,938	2,373	2,243	2,345	2,413	2,399	2,954	5,741	24,248	7,690	16,557	6,484	23,041
	Month 1 - Actual/Forecast	1,068	1,123	1,333	1,037	1,692	1,649	1,978	1,835	1,944	1,987	2,016	2,762	4,561	20,424	7,258	13,166	6,029	19,195
	Variance	0	(0)	(254)	(926)	(150)	(289)	(395)	(408)	(401)	(425)	(383)	(192)	(1,180)	(3,823)	(432)	(3,391)	(455)	(3,846)
	In Year - Plan	641	554	1,378	1,622	432	475	470	470	467	702	374	499	4,195	8,084	5,114	2,970	625	3,595
	In Year - Actual/Forecast	0	267	1,178	1,969	491	418	404	398	394	397	397	754	3,413	7,067	4,879	2,188	333	2,521
	Variance	(641)	(287)	(200)	346	59	(57)	(66)	(72)	(73)	(304)	23	255	(782)	(1,017)	(235)	(782)	(292)	(1,074)
	Total Plan	1,709	1,678	2,964	3,586	2,275	2,413	2,843	2,714	2,811	3,114	2,773	3,453	9,937	32,332	12,804	19,528	7,109	26,636
	Total Actual/Forecast	1,068	1,390	2,511	3,006	2,183	2,067	2,382	2,233	2,338	2,385	2,413	3,516	7,975	27,491	12,137	15,354	6,362	21,716
	Total Variance	(641)	(288)	(453)	(580)	(91)	(346)	(461)	(481)	(473)	(729)	(360)	63	(1,962)	(4,841)	(667)	(4,173)	(747)	(4,920)

Summary of Forecast Month 1 & In Year (£000's) - Green & Amber	Cash-Releasing Saving (Pay)	Cash-Releasing Saving (Non Pay)	Cost Avoidance	Savings Total	Income Generation	Accountancy Gains
All Service Areas	2,872	2,280	0	**5,153**	486	0
Scheduled Care	3,421	2,983	0	**6,403**	167	0
Unscheduled Care	87	125	0	**212**	0	0
Mental Health	764	911	0	**1,675**	0	0
Community Services	1,066	410	0	**1,476**	0	0
Primary Care	330	1,492	0	**1,821**	0	0
Commissioned Services - CHC	0	430	0	**430**	0	0
Commissioned Services - Specialised Services	0	1,078	0	**1,078**	573	0
Other Commissioned Services	0	0	0	**0**	0	0
Clinical Support	1,531	1,651	0	**3,182**	462	600
Non Clinical Support	34	0	0	**34**	0	0
Executive / Corporate Areas	681	2,084	0	**2,765**	701	0
Total	**10,786**	**13,442**	**0**	**24,229**	**2,390**	**600**

Cyfarwyddyr Cyffredinol Grŵp Iechyd, Gofal Cymdeithasol a'r Blynyddoedd Cynnar / Prif Weithredwr GIG Cymru

Director General Health, Social Care & Early Years Group / NHS Wales Chief Executive

Llywodraeth Cymru
Welsh Government

Suzanne Rankin
Chief Executive
Cardiff and Vale University Health Board

Our Ref: JP/HJ/SB

12 September 2025

Dear Suzanne

2025/26 Financial Position – Cardiff & Vale University Health Board

Thank you for our meeting on 11th September and for attending in person at Cathays Park, I valued the in-person and candid discussion, and you shared that you understand the gravity of the position and importance of improvement actions.

The detailed information pack you provided was helpful, recognising we didn't have the chance to review and discuss all associated detail I have asked Hywel and his team to review and follow up through our established mechanisms in addition to the actions we agreed.

I wanted to capture the key aspects and next steps from our discussion, namely:

- You described the health board was off-plan in-year, and had a challenging month 5 position, but you were focussed and committed to delivering the £56.2m deficit forecast. We discussed your current Clinical Board deep dives and process mechanisms to shore up delivery.

- On savings, you described confidence in £28.9m of your £32m savings plan requirement, a shortfall of £3.1m. We discussed this did not meet the expectation of 100% confidence in delivery by 11th September, and challenge that the health board has been reporting a high confidence in savings delivery for some time but had been unable yet to fully close the savings gap. We acknowledged the important of the health board having granular actions that would deliver with confidence.

- We discussed at length the challenge of the health board having such a deteriorated financial position in 2025/26, and the frustration at the lack of progress at reducing

the forecast £56.2m deficit. We covered the additional in-year pressures and risks above plan that had impacted the health board's ability to deliver improvement, and that additional opportunities had been progressed but consumed by off-setting in-year pressures.

- Your position sets out that the health board would be unable to reduce the deficit beyond £56.2m without consequences to Cabinet Secretary performance delivery expectations, or other service impacts such as capacity to support winter.

- **You committed to ensuring that through your ongoing processes and Board interactions you would finalise clear actions to deliver with confidence your savings in full, and all actions to deliver a £56.2m deficit at a minimum by your month 6 monitoring return on 13th October**. Welsh Government maintain the expectation that in addition to risks being mitigated the health board delivers actions to continue to reduce the deficit both in-year and on a recurrent basis.

- On outstanding risks, I emphasised the expectation the health board would deliver the actions required to off-set the shortfall in funding on employers' national insurance and understood that the risk associated with the Welsh Risk Pool sat outside of your current forecast but required action. On Band 2/3, I emphasised that there was no funding available from Welsh Government to support that risk.

- We discussed the need to strengthen the consideration of the escalation and support arrangements in place for the organisation, which may include additional capacity and intervention support. Hywel and Catherine would assess this further along with a prioritised action plan at their meeting of 24th September.

- You sought clarity on cash support. We confirmed the well-established process mechanisms in place and the working assumption that working capital and routine allocations would be supported in cash terms. Welsh Government cannot provide assurance on cash assistance to support the health boards deficit without certainty to forecast delivery in line with actions to deliver a balanced MEG.

- Finally, we all recognised the important of greater recurrence to savings delivery and financial improvement actions, and that translating into a step-change in the financial forecast in 2026/27.

Please liaise directly with Hywel and team as required over coming weeks to maintain momentum at this critical milestone.

Yours Sincerely

Judith Paget

Judith Paget CBE

cc: Hywel Jones
Catherine Phillips