

**Draft Minutes of the Public Finance & Performance Committee Meeting
17 September 2025
Via MS Teams**

To view a recording of this meeting, please [click here](#).

Chair:		
John Union	JU	Independent Member – Finance / Committee Chair
Present:		
Ceri Phillips	CP	CAV UHB Vice Chair
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
Rachna Uphadya	RU	Independent Member - General
Clive Curtis	CC	Independent Member - Community
In Attendance:		
Catherine Phillips	CP	Executive Director of Finance
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
Vicky LeGrys	VL	Programme Director Strategic Clinical Redesign
Robert Mahoney	RM	Deputy Director of Finance (Commissioning)
Secretariat:		
Nikki Regan	NR	Corporate Governance Officer
Apologies:		
Paul Bostock	PB	Chief Operating Officer
Charles Janczewski	CJ	UHB Chair

Ref:	Agenda Item:	Action:
FPC 17/09/1.1	<u>Welcome & Introduction</u> The Committee Chair (CC) welcomed everyone to the meeting.	
FPC 17/09/1.2	<u>Apologies for Absence</u> Apologies for Absence were noted. The Finance and Performance Committee resolved that: a) Apologies for Absence were noted.	
FPC 17/09/1.3	<u>Declarations of Interest</u> No declarations were noted. The Finance and Performance Committee resolved that: a) No declarations of interest were noted.	
FPC 17/09/1.4	<u>Minutes of the Finance and Performance Meeting held on 23 July 2025</u> The minutes of the meeting held on 23 July 2025 were received and confirmed as a true and accurate record following minor amendments. Add Clive as apologies & amend CP as apologies only. The Finance Committee resolved that:	

	a) The minutes of the Finance and Performance Committee meeting held on 23 July 2025 were held as a true and accurate record of the meeting.	
FPC 17/09/1.5	<p><u>Actions following the Finance & Performance Meeting on 23 July 2025</u></p> <p>The CC confirmed all actions are complete.</p> <p>FPC 23/07/3.2 - The EDF noted the Parkview business case has gone back into the service to understand the service changes needed to make it more affordable and clarified it is not on the current agenda but needs to go on the forward plan.</p> <p>FPC 23/07/2.4— enabling actions in the MAG report, will now be a standing item and will provide updates as required – Action Complete.</p> <p>The Finance and Performance Committee resolved that:</p> <p>a) The Action Log for the Finance and Performance Committee was noted.</p>	
FPC 17/09/1.6	<p><u>Chairs Action since previous meeting</u></p> <p>There were no Chair's Actions taken since the last meeting</p>	
FPC 17/09/2.1	<p><u>Financial Report – Month 5 Position (including savings tracker)</u></p> <p>The DDFS gave an update on the financial report at month 5 and highlighted the following:</p> <ul style="list-style-type: none"> • Reported a deficit of £27.8m at month 5, which is £4.4m over the planned deficit of £23.4m. • The £4.4m variance is split into a £1.5m deficit against the savings programme and a £2.9m operational deficit. • The savings programme is £3.1m short of the £32m million target, with £28.9m identified in green and amber schemes. • Mental health out-of-area placements are above plan, with 11 patients per month versus a plan of 7, and spikes up to 19; this is a national issue post-COVID. • Cardiology contract underperformance continues; plans are in place to use additional locum consultants to address this. • Critical care income is down due to more Cardiff patients occupying beds; a review is underway to understand the change in patient mix. • A £1 million provision was made for GP out-of-hours pay resolution, impacting the month's figures. • Deep dives with clinical boards were held to identify further actions; some boards have plans to recover, but gaps remain, especially in specialist services and children/women's services. • A vacancy freeze was implemented as an additional control to help close the gap. • Welsh Government has made clear that the £56.2m planned deficit must be met, with no leeway or additional support. • Risks include the band 2-3 corrective payments (not currently in figures), underlying deficit, and cash management. <p>The IMCE questioned the confidence behind the statement in the financial report that the unachieved CRP gap and operational pressures at month five will be managed and mitigated as the year progresses, especially as the position appears to be drifting each month. She asked if the series of deep dives with clinical boards and the assurances from those meetings, along with plans to revisit boards needing more support, were providing Andrew with the confidence to maintain that statement in the report.</p> <p>The DDFS responded that while the report aligns with holding the £56.2m forecast deficit, there is not yet full confidence that the gap is closed, but progress has been made through the deep dives and further actions (like the vacancy freeze) are in place if needed.</p> <p>The IMDH asked what interactions had taken place with Welsh Government regarding the deteriorating financial position and the deep dives, especially now that the organisation is under targeted intervention.</p> <p>The DDFS explained that there have been two formal targeted intervention meetings with Welsh Government at the executive level, but the formal position on how targeted intervention will work, what support will be provided, and expectations for progress are still being discussed. He also noted that Welsh Government has made it clear there is no scope for missing the £56.2m</p>	

target, and risks previously considered outside the plan are now expected to be managed by the organisation.

The EDF added that the process is ongoing, with 280 lines of concern/actions from Welsh Government being validated, and that more clarity is expected as part of the planning cycle.

The IMLA asked for clarification on when, during the financial year, action would be taken if the financial trajectory continued to deteriorate, referencing assurance sought at the last Board meeting and mentioning that month 6 was previously identified as a key point for intervention.

The EDF responded that month 6 was a proxy for when a clear position and profile of actions would be available but emphasized that detailed information and evidence to answer the question fully were not yet available, and plans were still being developed. She also noted that Welsh Government expects a clear position on savings and overall forecast by the end of the current month, and that the organisation is working towards having the necessary information to monitor progress.

The IMLA expressed concern that if, after completing the deep dives with the clinical boards, the organisation is still not assured of meeting the financial target, there is a risk of reaching the end of the calendar year without assurance of achieving the target. She specifically asked what steps would be taken if, after the deep dives, the gap remains.

The EDF replied that, beyond the deep dives, the main remaining tool is a vacancy freeze, which is already being implemented. If the gap persists after this, the next steps would involve considering actions that are suboptimal from a service delivery perspective, such as closing or limiting services. She emphasized that the vacancy freeze carries risks and that, if further action is needed, it would involve difficult decisions impacting service delivery.

The IMG raised concerns about ensuring that cost savings are sustainable and questioned how the organisation can be sure it is not simply deferring costs, which could create greater pressures in future years.

The DDFS responded that this issue was discussed in detail with every clinical board, emphasizing the need to achieve the £56.2m deficit target recurrently, not just in-year. He explained that the focus is on both in-year and recurrent savings, as well as identifying and addressing operational pressures that could carry over into the next year. He assured that clinical boards are providing assurance on both in-year and recurrent positions, and this will be included in future reports. He highlighted the following points:

- The sustainability of cost savings were confirmed and the need to meet the £56.2m deficit recurrently (not just in-year) was discussed in detail with each clinical board. He highlighted that the focus was on in-year savings, recurrent savings, operational pressures that could impact future years, and how these are being addressed. Clinical boards provided assurance on both the in-year and recurrent positions.
- The workforce data tracked whole time equivalent (WTE) reductions, with a decrease of 168 WTE between April and August 2025.
- The vacancy freeze has resulted in 80-90 leavers per month across CAV UHB, with an estimated 20% of those vacancies being critical posts that must be filled. This could result in a net reduction of 60-70 posts per month, contributing significantly to cost savings.
- This approach could deliver upwards of £3.1m in savings by year-end, and that vacancy control panels are in place at all levels to monitor and approve critical posts only.
- CAV UHB need to consider the influx of new staff from universities, which will offset some of the reductions.

The IMLA asked for assurance regarding the previous meeting, where there were two reports with different figures around whole-time equivalents (WTE), and it was agreed that steps would be taken to address this issue. She requested a brief update on what actions had been taken for assurance.

The DDFS confirmed that steps had been taken, explaining that the organisation uses two numbers when looking at workforce: staffing posts and WTE. He clarified that the focus is now on WTE reductions, as this directly relates to pay bill costs, and that timelines have been aligned across departments to ensure consistent reporting.

The Finance and Performance Committee resolved that:

	<p>a) The reported year to date position is an overspend of £27.809m and the forecast deficit of £56.2m was noted.</p> <p>b) The month 4 operational overspend against plan of £2.913m and the £1.466m savings deficit was noted.</p> <p>c) 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 was noted.</p> <p>d) That delivery of the forecast is also predicated on the confirmation of all expected income streams was noted.</p> <p>e) The £8.480m recurrent savings shortfall impacting adversely on a deteriorating underlying deficit being carried into 2026/27 was noted.</p> <p>f) The is a potential £131.0m cash shortfall at year end before outstanding cash allocations and strategic support are confirmed by Welsh Government was noted.</p>	
<p>FPC 17/09/2.2</p>	<p><u>Operational Performance Update</u></p> <p>The DOPP presented on the Operational Performance Update, , focusing on five sections: urgent/emergency care, planned care, primary/community care, mental health, and productivity/efficiency and highlighted the following points:</p> <ul style="list-style-type: none"> • Urgent/emergency care: Attendance at the emergency department reduced in August compared to July but remained higher than the previous year and winter months. The usual seasonal reduction in attendances was less pronounced this year. 46:01 46:20 • Despite increased demand, improvements were seen in emergency department waiting times, with 12-hour waits to drop below 7% and only two patients waiting over 24 hours in August. • Ambulance handover delays improved significantly due to the West 45 initiative, reducing 45-minute waits from nearly 600 in July to 114 in August. • Out of hospital: General practice appointments increased slightly, and access standards were being met. Community independent prescribing also showed positive progress. • Hospital flow/discharge: Stroke care improved, with more patients scanned and admitted to the ward within target times. Pathway of care delays increased, with most delays attributed to social care or joint health/social care responsibilities. • Planned care: Single cancer pathway performance remained below target but was the best in Wales. Backlogs in skin cancer and urology were noted, with plans in place to address them. • Long-waiting patients: The number of patients waiting over 52 weeks for outpatient appointments reduced, with further improvements expected from the national insourcing scheme. • Diagnostics: Non-obstetric ultrasound, MRI, and CT positions worsened in August due to staff leave, equipment issues, and delays in independent sector support, but recovery plans were in place. Endoscopy improved and was ahead of trajectory. • Primary/community care: Increased activity in pharmacies, dental, and community services. Efforts were ongoing to build capacity for winter, including discussions to expand Barry Hospital's minor injuries unit. • Mental health: Good performance in children's services, but neurodevelopmental services continued to face long waits. Adult mental health saw improved assessment times, with further work needed on part 2 performance. • Productivity/efficiency: Some positive areas (e.g., endoscopy utilisation), but outpatient DNA rates remained high. Ongoing work was focused on improvement, with a detailed update planned for the next board meeting. <p>The CC observed that the total number of children on the neurodevelopment service waiting list for assessment (4,512) was a large figure and asked if CAV UHB was an outlier compared to other health boards.</p> <p>The DOPP responded that while the number is the highest it has been and continues to increase. Whilst all health boards face challenges, CAV UHB stood out due to some of the longest wait times.</p> <p>The IMCE noted a reference in the paper to a "reset week" and asked for an explanation of what a reset week involves, what investment is required, and what it typically delivers for the organisation.</p> <p>The DOPP explained that during a reset week, clinical boards and teams focus on inpatient positions and the front door, increasing senior clinical reviews, ward rounds, multidisciplinary team meetings, and support for discharge. It does not necessarily require additional financial</p>	

	<p>investment, as staff reorganise their time. The aim is to improve patient flow and discharge rates, though recent reset weeks did not yield the expected improvements.</p> <p>The UHB VC noted that the Minister for Mental Health and Well-being is very active in the neurodevelopmental area, visited the team at St David's Hospital, and was impressed with their work. He highlighted the difficulty of the area due to increasing demand and the complexity of diagnosis, mentioning that some parents seek a diagnosis as a "ticket" and may obtain one online, which then needs to be validated by a professional.</p> <p>The Committee resolved that:</p> <p>a) The year-to-date position against key organisational performance indicators for 2025-26 and the update against the Operational Plan programmes was noted.</p>	
<p>FPC 17/09/2.3</p>	<p><u>Board Assurance Framework</u></p> <p>The DDFS described the paper as a discussion document linked to financials, aiming to understand the impact of current decisions. He noted the organisation typically works with Welsh Government on a three-year planning cycle. He mentioned the approach involves looking at prevention and demand at a high level and considering how to assure that current decisions will have the desired impact and when these effects will begin. He proposed linking the long-term financial model to the Clinical Services Plan (CSP), with engagement across the organisation, and stated that this would be reviewed by various committees.</p> <p>The UHB VC stated that the proposal was very welcome and fully supported but questioned if it was far enough. He noted that outcomes were not mentioned in the paper and emphasized the importance of considering where resources are allocated to maximize outcomes for patients. They suggested incorporating outcomes to ensure resource allocation delivers maximum patient benefit.</p> <p>The EDPH expressed strong support for the work and suggested using return on investment and the benefits realisation/value group methodology. She noted that while people are interested in what additional investment can deliver, it's also important to consider how to reduce predicted future spending through long-term modelling, especially for expensive current expenditures and long-term conditions.</p> <p>The DOPP asked if other health boards or health systems have done something similar, questioning whether there is an off-the-shelf model that could be adapted or if it would need to be developed from scratch.</p> <p>The DDFS stated that a model has already largely been built to be populated with data and will be refined through its first iteration. He emphasized that the roadmap to financial sustainability must be steeped in the reality of demand, operational pressures, and the scale of transformation required; otherwise it will not be useful.</p> <p>The IMLA agreed that developing the long-term financial model seems essential and expressed support for it. She noted a gap regarding critical dependencies on external partners, emphasizing the importance of considering whether external dependencies might impact the ability to deliver and ensuring this is built into the plan.</p> <p>The DDFS noted there will be economic modelling available for assessing uplifts from Welsh Government and inflationary pressures, and that the model should be based on as much evidence as possible. He stated it will be tricky to monitor demand for all services over the next 10 years and while high-level demand assumptions can be made, making them granular at the specialty level will be challenging. He also said the model will be aligned to the Clinical Services Plan (CSP) and he would like to wrap financial modelling around it as a starting point.</p> <p>The Committee resolved that:</p> <p>a) The proposal for developing of a long-term financial model aligned to the Health Board Strategy and Clinical Services Plan was discussed and noted.</p>	
<p>FPC 17/09/3.1</p>	<p><u>Business Case for Information & Support</u></p> <p>Llantrisant Health Park (LHP) Outline Business Case</p> <p>The PDSCR introduced the LHP OBC and highlighted the following:</p> <ul style="list-style-type: none"> It is a capital case led by Cwm Taf Morgannwg with support from Welsh Government, and that CAV UHB is working closely in partnership on its development. She emphasized its importance for regional planning and future service delivery. 	

	<ul style="list-style-type: none"> • The hub's alignment was described with strategy for quality and equitable care, its role in supporting workforce development, and its dependency on successful regional collaboration, highlighting key risks around revenue funding and workforce planning. • The case supports phase one of the build, focused on the community diagnostics hub (including endoscopy suite and training academy), and aligns with the regional endoscopy plan previously approved by F&P and board. • The unusual planning approach required by Welsh Government was noted, which asks for regional commitment before detailed service planning is complete, and outlined ongoing risk management efforts. • Engagement with communities and communication about travel/access to LHP is being addressed through a regional portfolio, including a patient sounding board to consider concerns. <p>The EDF noted the risks as we don't know the full-service model and cost but seeking full support.</p> <p>The IMG was interesting and suggested that when it comes to Board, it would be good to see more information about the impact LHP could have, specifically regarding the community and benefits for waiting lists.</p> <p>The PDSCR responded by noting that since the endoscopy plan came earlier, they will draw out several of the benefits described in that plan and bring them forward, ready for the CAV UHB Board.</p> <p>The CC asked whether there was any comment about travel for CAV UHB population to Llantrisant Health Park (LHP) and whether this was included in the business case, specifically mentioning community engagement and working with local authorities.</p> <p>The PDSCR noted that engagement remains a risk for their communities but is being addressed through the regional portfolio and the LHP programme, with the Director of Comms and Engagement leading a regional piece of work. She mentioned a recent briefing by Llais and that a patient sounding board, including members of their population, has been set up to specifically look at concerns around travel and access as the programme progresses.</p> <p>The DDFC stated that they know they will need the physical capacity and support it in principle as a regional solution, but at present do not have line of sight to revenue funding, costs, or the full-service model. He emphasized that their position is to recognize the need for this physical capacity, even though these variables are not yet clear.</p> <p>The CC asked if, on the basis that this is delivered as a regional diagnostic hub, their provisions would move to the hub and whether they would stop providing this in their own hospitals.</p> <p>The DDFC confirmed that the hub is for excess demand and that they are looking to absolutely maximise in-house provision. He clarified that this capacity is in addition to home services, which will be bolstered for efficiency, and the hub will handle demand that home services cannot meet.</p> <p>The CC asked for the recommendations to be amended to include that the committee is supporting and recommending to CAV UHB Board, specifying that support is on the basis that sufficient revenue will be available should capital be agreed by Welsh Government, to enable operation for excess demand. He requested for the CGO to take this on board for the recommendations.</p> <p>Action – The CGO to update the wording on the cover paper in readiness for CAV UHB Board.</p> <p>The Committee resolved that:</p> <ol style="list-style-type: none"> a) The committee agreed to support and recommend the Llantrisant Health Park business case to the board, with the condition that Welsh Government would need to fully fund additional costs to operate the additional capacity for excess demand. 	
<p>FPC 17/09/4.1</p>	<p><u>Monthly Monitoring Return – Month 3 & 4</u></p> <p>The Monthly Monitoring Report for month 3 & 4 was noted.</p> <p>The Committee resolved that:</p>	

	a) The monthly monitoring return for month 3 & 4 was noted.	
FPC 17/09/5	<p><u>Any Other Business</u></p> <p>The UHB VC thanked the CC for all his hard work and commitment on behalf of the Board and colleagues.</p> <p>The Committee resolved that:</p> <p>a) Any other business was noted.</p>	
FPC 18/06/013	<p><u>Review & Close</u></p> <p>To note the date, time and venue of the next Committee meeting: Wednesday 22nd October 2025 via MS Teams</p>	