Public Finance & Performance Committee Meeting

Wed 19 November 2025, 14:00 - 15:15

Virtual - MS Teams

Agenda

14:00 - 14:05
5 min

1. Standing Items

1.1. Welcome, Apologies & Introductions

Rhian Thomas

1.2. Declarations of Interest

1.3. Minutes from the Finance & Performance Committee meeting on 22.10.2025

Rhian Thomas

1.3 - Draft Public Finance and Performance Minutes 22.10.2025.pdf (6 pages)

1.4. Actions following th Finance and Performance Committee meeting held on 22.10.2025

Rhian Thomas

1.4 - Public Action Log.pdf (1 pages)

1.5. Chairs Actions since previous meeting

14:05 - 15:15
70 min

2. Items for Review & Assurance

2.1. Financial Report - Month 7 Position (including savings tracker) (25 MINUTES)

Andrew Gough

2.1 M07 Finance Report.pdf (20 pages)

2.2. Operational Performance Update (20 MINUTES)

Paul Bostock

2.2 Operational Performance Report NOV 25 (1).pdf (15 pages)
2.2a Integrated Performance Report F&P committee Nov 25.pdf (16 pages)

2.3. Planning Maturity Self Assessment (10 MINUTES)

Jonathan Watts

2.3 Maturity Matrix FINAL.pdf (5 pages)
2.3a Appendix 1 Planning Maturity Matrix 2025 levels.pdf (11 pages)
2.3b Appendix 2 Planning Maturity Action Plan.pdf (4 pages)

2.4. Accountable Officer Letter (5 MINUTES)

Andrew Gough

2.4 Accountable Officer Letter _ Strategic Cash Request 2025_26 (1).pdf (3 pages)

2.5. Board Assurance Framework - Decarbonisation & Climate (10 MINUTES)

Andrew Gough

- 2.5 Board & Committee Covering Report BAF Decarboniastion and Climate F&P 19.11.25.pdf (2 pages)
- 2.5a Board Assurance Framework.pdf (39 pages)
- 2.5b F&P - Sustainability and Climate Response.pdf (13 pages)

15:15 - 15:15
0 min

3. Items for Approval / Ratification

3.1. No Business Cases

15:15 - 15:15
0 min

4. Items for Information & Noting

4.1. Monthly Monitoring Return - Month 6

Andrew Gough

- 4.1a WG 2025 _26 month 6 MMR Covering Report.pdf (2 pages)
- 4.1b CV Financial Monitoring Returns 2025-26 - Month 6.pdf (14 pages)
- 4.1c 2024-25 MMR Template - Cardiff Vale UHB Month 6.pdf (4 pages)

15:15 - 15:15
0 min

5. Any Other Business

Rhian Thomas

15:15 - 15:15
0 min

6. Private Agenda

- ***2026 Financial Plan***
- ***Business Cases***

15:15 - 15:15
0 min

7. Review & Final Closure

Rhian Thomas

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

Rhian Thomas

7.2. To note the date, time and venue of the next Committee meeting: Wednesday 21st January 2026 via MS Teams

15:15 - 15:15
0 min

8. Declaration for Private Meeting

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]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Finance and Performance Committee resolved that:

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

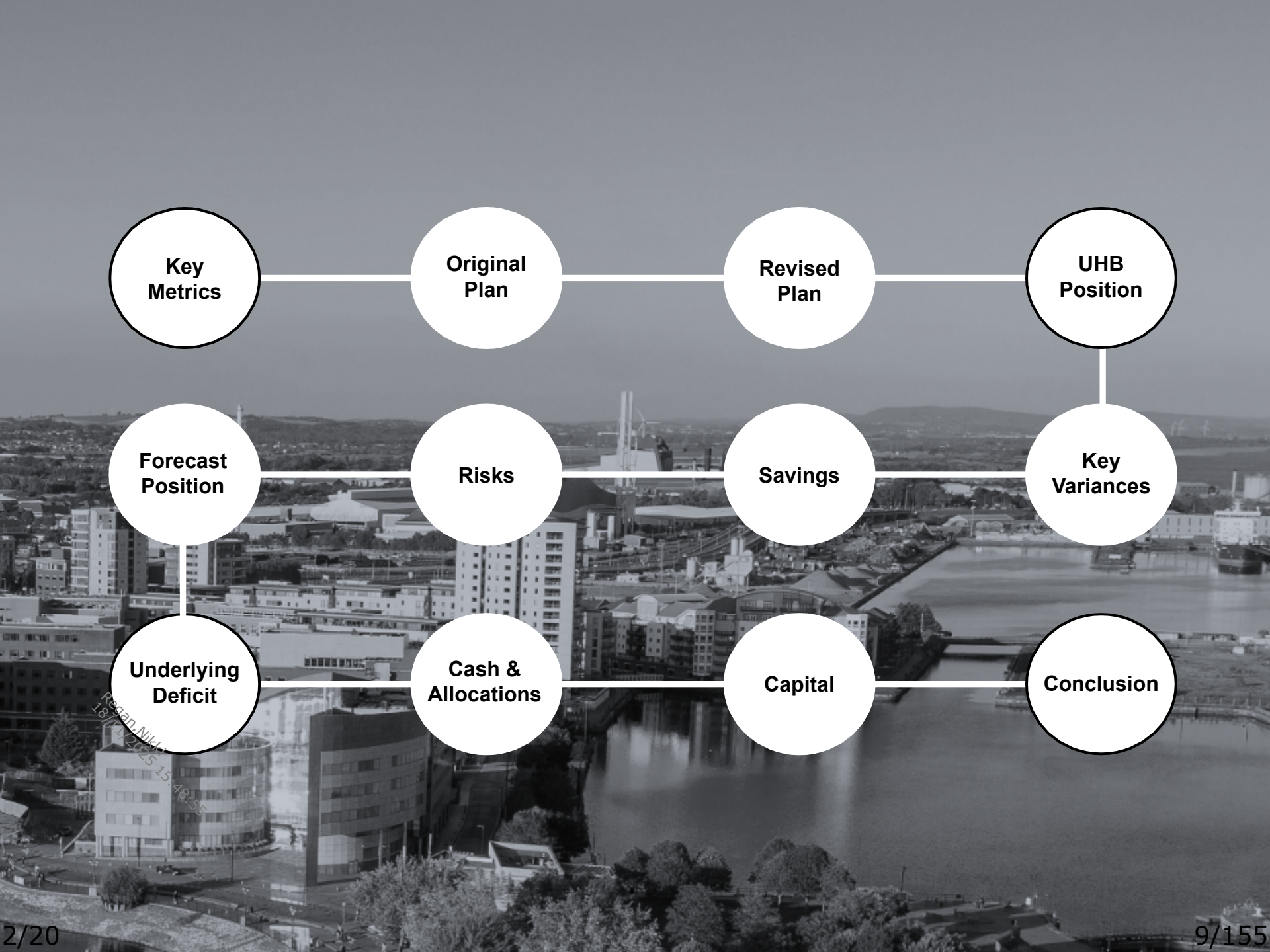
	SR asked if the agreed trajectories for 104-week waits this year were in writing from NHS, expressing concern about having formal documentation given the Cabinet Secretary's commitment to achieving zero 104-week waits. PB confirmed the agreed trajectories for 104-week waits were not in writing; he mentioned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

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

Public Action Log
Finance & Performance Committee
(Updated for the meeting being held 19th November 2025)

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE DUE	STATUS/COMMENTS
FPC 23/07/3.2	Park View Hub – Business Case	Returned to the service to identify changes needed to make it more affordable; not on the current agenda but must be added to the forward plan. The narrative will be amended to clarify this	Catherine Phillips	19.11.2025	**COMPLETE** Business Case added to Forward Plan for meeting 19.11.25
FPC 17/09/3.1	Llantrisant Health Park – Outline Business Case	The recommendation was to be amended for Board to include the need for assurance on sufficient revenue funding before supporting the business case, and to bring forward more detail on community impact and patient benefits.	Nikki Regan	18.09.2025	**COMPLETE** Business Case added to the Forward plan for meeting 19.11.25
FPC 17/09/2.2	Operational Performance Update	To take forward the action to resurrect district nurse contact data to provide insight into community interventions that avoid hospital admissions.	Paul Bostock	22.10.2025	**COMPLETE** Added to the forward plan for meeting January 2026
ACTIONS TO BE REFERRED TO BOARD / COMMITTEES:					

CARDIFF & VALE UHB
FINANCE REPORT – MONTH 7



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	M7 2025/26
Return to financial balance and approved IMTP status	£56.2m underlying deficit by end of 2025/26 financial year. Currently reporting recurrent savings gap after Month 7.	R	"	£56.2m	M7 2025/26
Management of operational budget pressures	Failure to adequately manage budget pressures. This is the responsibility of the primary budget holders. £3.162m operational deficit reported at Month 7.	A	$	Operational Spend to be maintained within Budgets	M7 2025/26
Delivery of recurrent £32.0m savings target	£32.592m Green and Amber schemes identified at Month 7, of which £26.700m were recurrent.	A	$	£32.0m	M7 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	M7 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 7, the UHB is reporting a year to date overspend of £35.619m, which includes a Planning Deficit £32.803m, a savings Programme surplus of (£0.345m) and an Operational Position deficit £3.161m

	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	7,673	7,673	0	49,253	49,253	0	88,233	88,233	(0)
Quality Efficiency Improvement Plans - Savings	(2,987)	(3,024)	(37)	(16,450)	(16,795)	(345)	(32,000)	(32,592)	(592)
Operational Variance	0	(873)	(873)	0	3,161	3,161	0	592	592
Clinical/Service Board Variance	**4,686**	**3,776**	**(910)**	**32,803**	**35,619**	**2,816**	**56,233**	**56,233**	**(0)**

At month 7 the UHB is reporting an overspend of £35.619m, £2.816m off plan. The month 7 position represents an in-month improvement of £0.910m against the £3.727m overspend against plan reported at month 6. The position at month 7 is supported by the release of a £1.3m Provision for the GP OOH service following new guidance from the BMA.

Following confirmation of the month 5 position, the UHB undertook deep dives for all clinical boards to understand the issues and risks and gain assurance on the actions required to deliver within their deficit control totals. Further measures were approved to arrest and recover the financial run rate. At month 7, the UHB's savings tracker reported a £0.592m surplus of green and amber schemes against the £32m in year target.

It is expected that the delivery of savings and operational pressures will be managed and mitigated as the year progresses and that the UHB will deliver its planned deficit position of £56.233m.

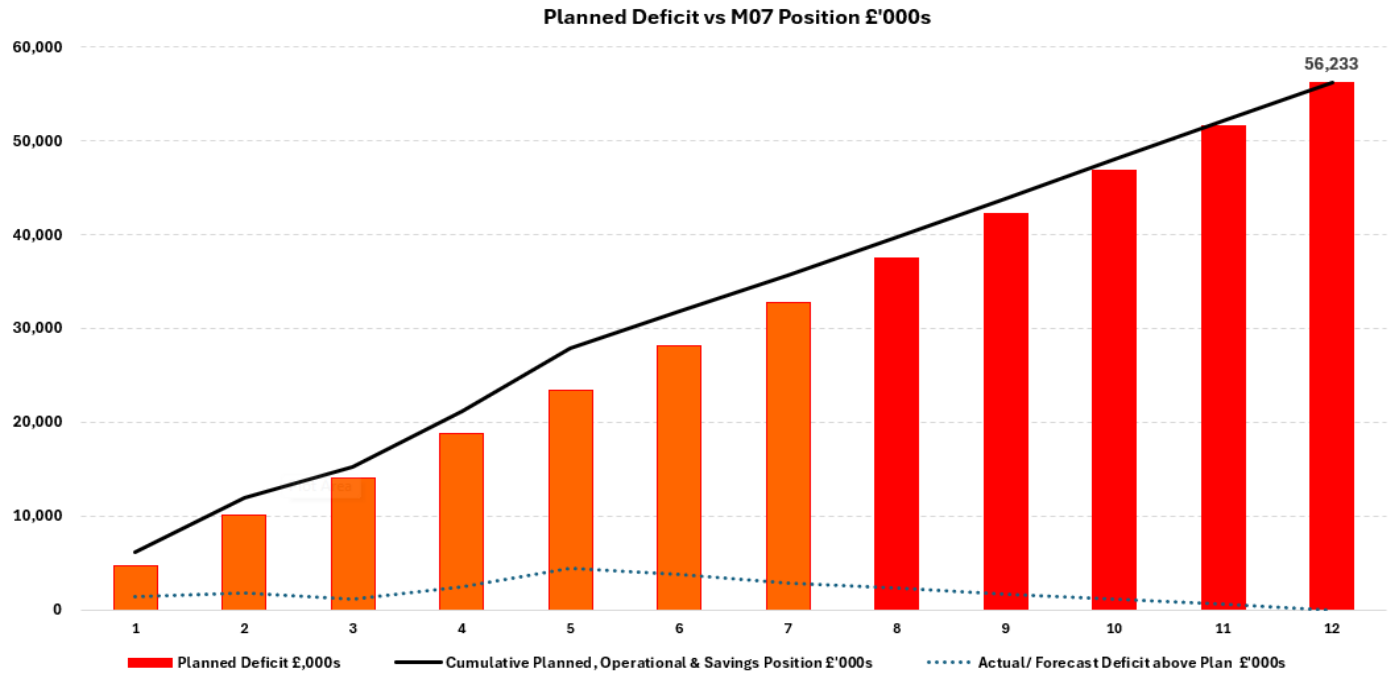
The following actions have been identified to halt and recover the deteriorating operational position.

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 October 2025 the overall number of staff in post has reduced by 147 WTE.
- Based on current turnover, a full vacancy freeze from 1st August (with requests to advertise critical posts only approved in exceptional circumstances) would likely equate to 350 staff leaving by end of the year, which the UHB would not replace. This could release up to £4.2 million in year.
- Only utilising additional winter capacity if absolutely necessary (£1.7m in plan)

UHB Position

The graph below shows the reported Month 7 position against the UHB's planned deficit of £56.233m



	1	2	3	4	5	6	7	8	9	10	11	12
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	31,843	35,619	39,742	43,865	47,987	52,110	56,233
Actual/ Forecast Deficit above Plan £'000s	1,410	1,803	1,158	2,428	4,379	3,727	2,816	2,253	1,690	1,127	563	0
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 7 , there was a Surplus of (£0.592m) against the £32.0m savings programme target. It is anticipated that the operational pressures reported at month 7 will be recovered and mitigated as the year progresses and that the UHB will deliver its planned deficit position of £56.233m.The expectation is that the monthly deficit will reduce as the UHB successfully identifies and delivers recovery and mitigating actions in year.

The table 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	(53,178)	87,696	96,142	**130,659**
(Income)/Expenditure	(54,353)	86,195	102,594	**134,435**
Variance	**(1,175)**	**(1,502)**	**6,452**	**3,776**
Cumulative	**£'000s**	**£'000s**	**£'000s**	**£'000s**
Budget	(369,586)	610,480	630,536	**871,431**
(Income)/Expenditure	(371,262)	609,109	669,202	**907,049**
Variance	**(1,676)**	**(1,372)**	**38,666**	**35,619**

A number of operational pressures continued into month 7 which in turn have been offset by pay vacancies, and the release of £1.3m of the Provision for the GP OOH service following new guidance from the BMA.

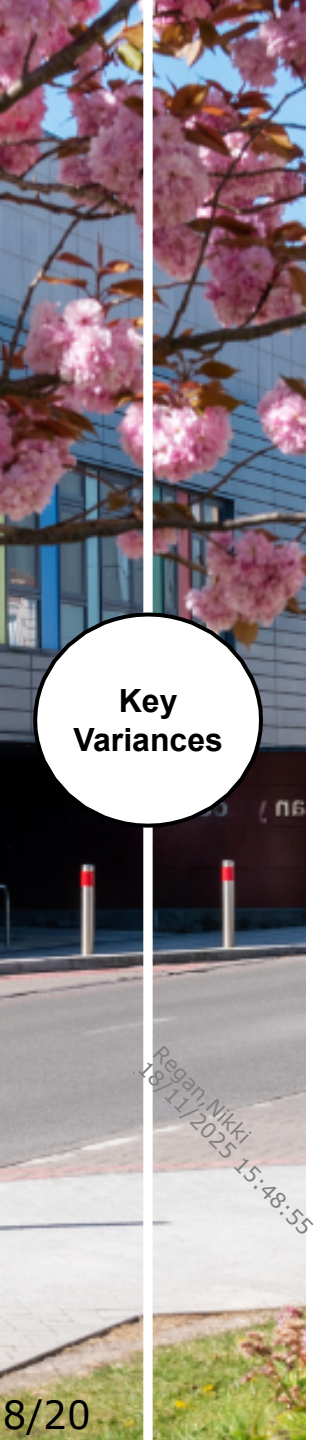
The following operational issues were reported in month 7:

- Income –There is reported underperformance in cardiac services where the UHB is reviewing activity flows. Performance against out of area critical care and BMTs improved in month.

- Pay – Vacancies along with enhanced scrutiny around variable pay partially 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 there was an average of 15 additional patients against plan in month and the acuity remains high. The shortfall in national funding for the 2025/26 NI increase is reported against non pay at £1.251m for the year to date (£2.145m full year). There is a risk against the JCC forecast outturn which is abated by the reduction in the forecast cost of Velindre drugs and recognized at £0.600m for the year to date. £32.530m of underlying deficit was included in non pay at month 7.

£35.619m of the deficit at month 7, is due to the £56.233m revised planning deficit with £2.816m of the deficit relating to in year operational pressures which are in part abated by the surplus against the savings target.



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	151	(117)	(78)	**(44)**	(194)
Children & Women	2,611	54	70	**2,735**	124
Capital, Estates & Facilities	3	171	(326)	**(151)**	(154)
Executives	(864)	78	(344)	**(1,130)**	(266)
Genomics	0	0	(55)	**(55)**	(55)
Medicine	8,245	(6)	133	**8,372**	127
Mental Health	4,072	(277)	1,413	**5,208**	1,136
Primary, Community & Intermediate Care	6,816	(390)	(472)	**5,954**	(862)
Specialist	2,394	232	1,888	**4,514**	2,120
Surgery	2,847	511	273	**3,632**	784
Sub-Total (Delegated Position)	**26,275**	**257**	**2,503**	**29,035**	**2,760**
Central Budgets	(4,789)	(602)	914	**(4,476)**	312
Commissioning	11,317	0	(257)	**11,060**	(257)
Sub Total (Non-Delegated Position)	**6,528**	**(602)**	**658**	**6,584**	**56**
Sub-Total Surplus/ Deficit	**32,803**	**(345)**	**3,161**	**35,619**	**2,816**

The table/chart below summarises the key 2025/26 Operational pressures as at month 7:

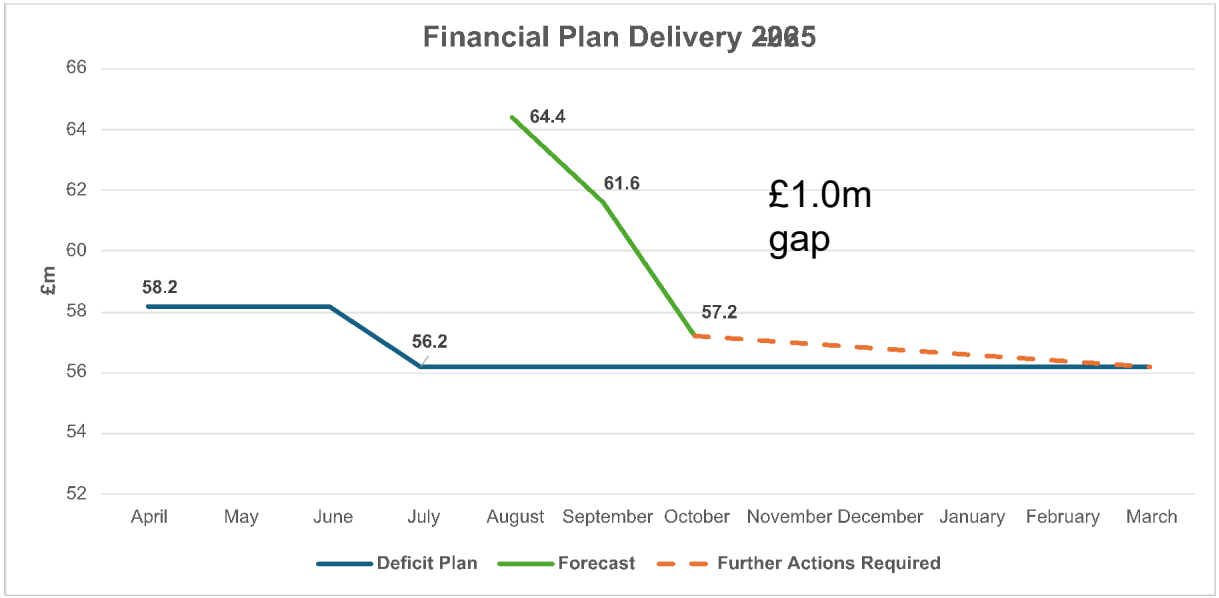
Operational Pressure	Operational Variance YTD £'000s	Operational Variance Forecast £'000s	Action
Mental Health Out Of Area Placements (OOA)	2,000	2,000	Continued Daily Review of all OOA patients. Full review of options for high cost patients including potential to release capacity through increased management of cases in the Community.
Specialist Services Activity Related Underperformance	1,900	0	Review coding and activity report. Evaluate operational practice to increase efficiency.
Employers NI (ENIC) Funding Gap	1,251	2,145	Plans to mitigate by holding vacancies & identification of further actions
JCC Forecast Outurn Growth	600	600	Continuing review with JCC required to understand options to mitigate and planning requirements.
Pay Vacancies & other mitigating actions to be agreed	(2,589)	(4,745)	Monthly monitoring to determine impact of recruitment policies on year end outturn and planning.
Sub-Total Surplus/ Deficit	**3,162**	**0**	

Following confirmation of the month 5 position, the UHB undertook deep dives for all clinical boards to understand the issues and risks and gain assurance on the actions required to deliver within their deficit control totals. Further measures were approved to arrest and recover the financial run rate and the UHB's saving tracker is now reporting a £0.592m surplus of green and amber schemes against the £32m in year target.

Further deep dive follow up meetings were scheduled with all clinical boards following month 6 reporting to understand the progress and delivery of all agreed deep dive actions with all Clinical Boards expected to deliver their target control totals supporting the Heath Board in delivery of the £56.2m deficit plan.

Forecast and Recovery Actions

As at month 7 the Health Board's gross forecast before recovery actions is £57.2m. This is £1.0m over and above our deficit plan of £56.2m. **The forecast assumes that the actions in place to halt and recover the deteriorating operational position will continue up to year end to ensure that the UHB delivers the forecast deficit and minimises the underlying deficit moving into 2026/27.**



Recovery actions agreed:

Delivery of all agreed deep dive actions
- a further £4.4m

RAG:

Continue all enhanced workforce controls including vacancy freeze (with exceptions) to support closing the remaining gap

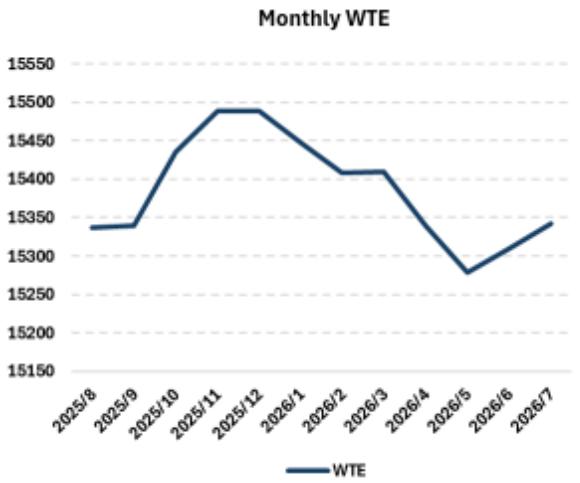
The table/chart below summarise the 2024/25 & 2025/26 Pay expenditure run rates at month 7 for all staffing groups (split by fixed and variable expenditure) :

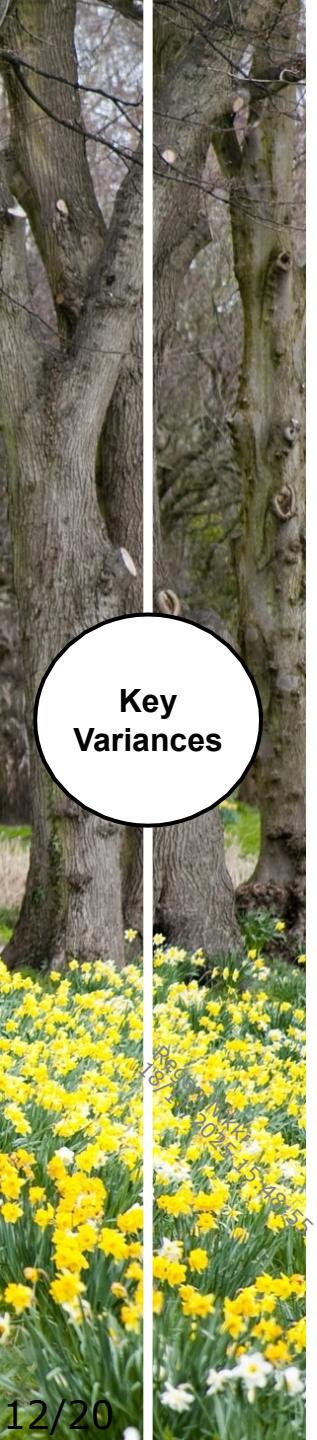
Staffing Group	2024/25 YTD (£m)	2025/26 YTD (£m)	2025/26 vs 2024/25 Growth (£m)	2025/26 vs 2024/25 Growth (%)
Additional Clinical Services	20,117	22,618	**2,501**	**12.4%**
Management, Admin & Clerical	65,784	74,834	**9,050**	**13.8%**
Medical and Dental	150,177	168,691	**18,514**	**12.3%**
Nursing (Registered)	150,232	173,123	**22,891**	**15.2%**
Nursing (Unregistered)	49,120	50,955	**1,835**	**3.7%**
Other Staff Groups	80,754	90,544	**9,790**	**12.1%**
Scientific, Prof & Technical	26,671	28,344	**1,674**	**6.3%**
Total	**542,855**	**609,109**	**66,254**	**12.2%**

Increased pay expenditure since April 2024 is supported by an increase in substantive headcount/Whole Time equivalent (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 11.5% of the increase in pay costs.

The chart (right) reports substantive WTE by month – and indicates a 5 WTE increase across the UHB over the last 12 months. A reduction of 105 wte staff is reported between April 2025 and October 2025. The majority of the increase in staff WTEs in September and October relates to registered nursing relating to nurse student streamliners.





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	73,768	76,311	**2,543**	**3.4%**
Continuing Healthcare	60,865	69,128	**8,262**	**13.6%**
Drugs / Prescribing	149,050	159,082	**10,031**	**6.7%**
Establishment Expenses	7,557	8,007	**450**	**6.0%**
General Supplies & Services	7,249	7,328	**78**	**1.1%**
Healthcare Provided Services	156,703	172,541	**15,838**	**10.1%**
Other Non Pay	38,521	48,554	**10,033**	**26.0%**
Premises & Fixed Plant	30,248	31,339	**1,090**	**3.6%**
Primary Care Contractors	90,191	96,914	**6,723**	**7.5%**
Total	**614,153**	**669,202**	**55,049**	**9.0%**

The UHB reported **£669.202m** of Non Pay expenditure for the year to Month 07 which is an increase of 9.0% on the same period in the previous year. The large part of the increase is driven by expenditure in the following areas:

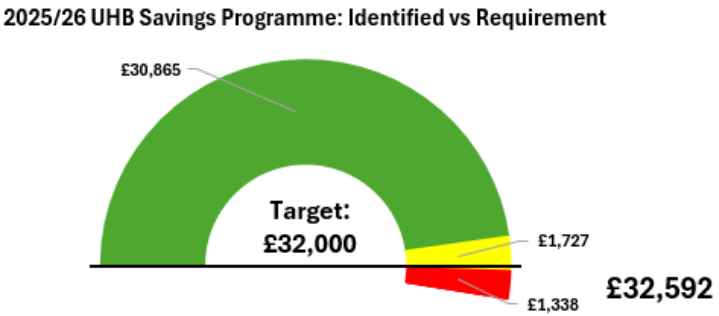
- Secondary Care & GP Prescribing
- Primary Care contracts (including contractual uplifts)
- Price and demand in Continuing Healthcare (CHC)
- Additional Commissioning cost including Mental Health Out of area Placements and JCC under Healthcare Provided Services.

Savings

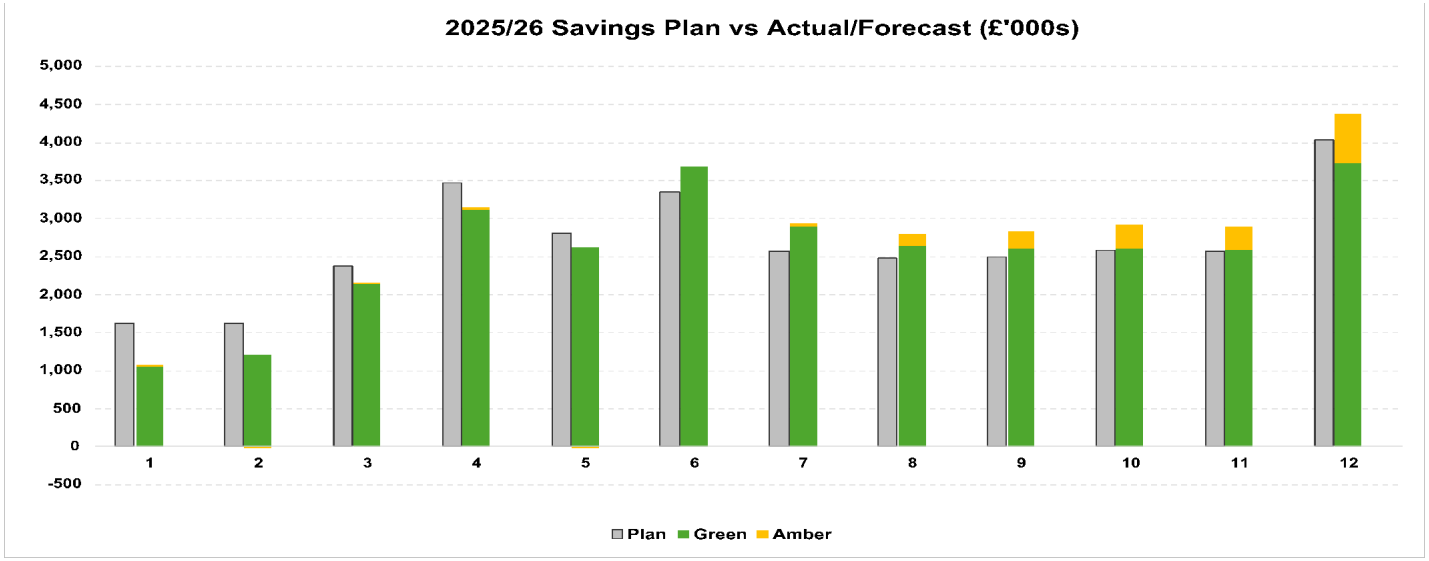
At Month 7, the UHB had identified £32.592m (101.9%) of green and amber savings to deliver against the revised £32.0m savings target. Red schemes of £1.338m were also identified and continue to be reviewed for progression to Green/Amber where possible.

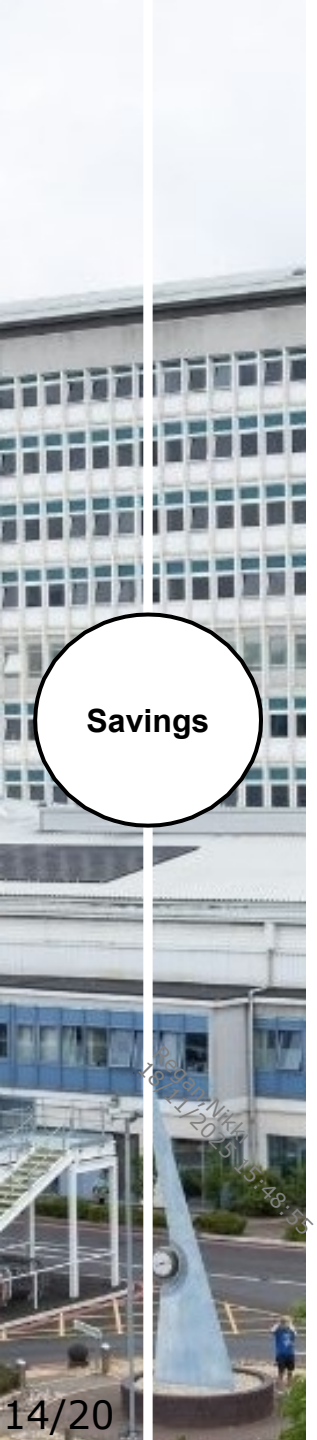
The forecast delivery against amber and green schemes was £ 32.592m at the end of month 7, which is 101.9% of the £32m savings target. The reported surplus of £0.592m is expected to mitigate ongoing operational pressures.

Further action is required to meet the recurrent target and the UHB continues to press all parts of the organisation to agree urgent actions that will accelerate savings to mitigate ongoing risks on a recurrent basis. £26.700m of recurrent were identified leaving a gap of £5.300m against the £32m recurrent target



The chart below illustrates the back-ended profile of the UHB's 2025/26 savings programme.





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	-	1,649	0	**1,649**
Children & Women	-	1,349	30	**1,379**
Capital, Estates & Facilities	-	730	98	**828**
Executives	-	1,446	0	**1,446**
Genomics	-	0	0	**0**
Medicine	-	482	0	**482**
Mental Health	-	0	0	**0**
PCIC	-	1,291	0	**1,291**
Specialist	-	1,270	0	**1,270**
Surgery	-	546	44	**590**
Sub-Total (Grip & Control)	**10,000**	**8,762**	**172**	**8,934**
Medicines Management	3,500	5,494	70	**5,565**
Income Generation	1,000	1,846	665	**2,511**
Continuing Healthcare	2,000	856	0	**856**
Facilities and Estates / Service Reconfiguration	1,000	244	13	**257**
Value/Clinical Variation	0	216	0	**216**
Procurement	3,500	3,576	75	**3,651**
Workforce - Temporary Pay	5,500	3,176	333	**3,509**
Workforce Restructuring	5,500	5,629	399	**6,027**
Corporate Opportunities		1,066	0	**1,066**
Sub Total (Cost Improvement Themes)	**22,000**	**22,103**	**1,555**	**23,658**
Sub-Total Surplus/Deficit	**32,000**	**30,865**	**1,727**	**32,592**

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 October 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 £8.185m	20
Identification and Delivery of additional savings to bridge £8m shortfall due to gap against Recurrent Savings Target & Recurrent Operational Pressures	20

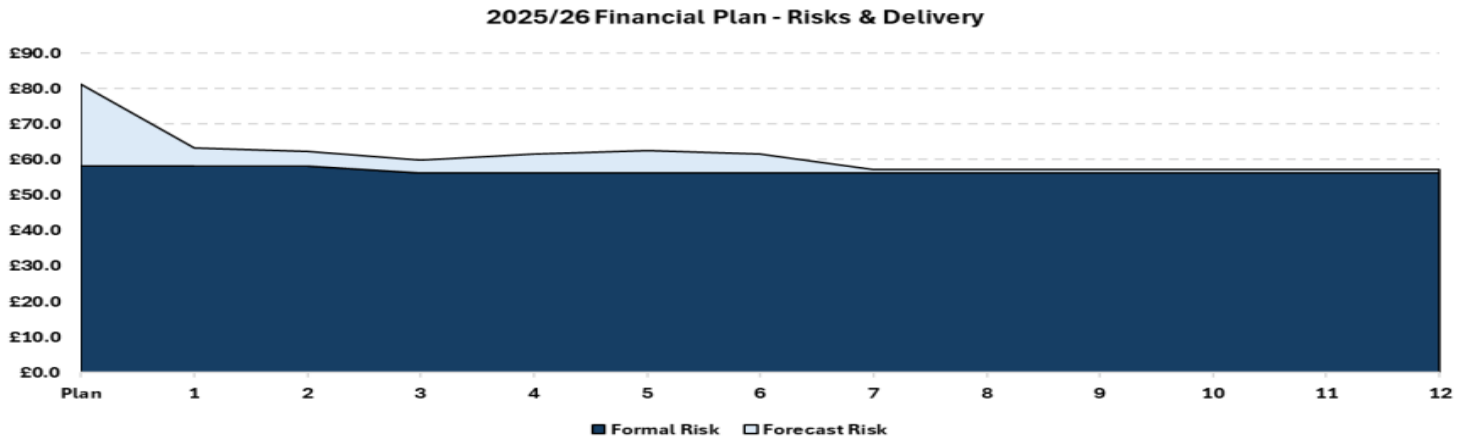
Forecast Position

The UHB draft plan submitted at the end of March 2025 included an inherent risk to the achievement of the £58.233m planned deficit due to a £23m gap in identified savings against the £30m target. At month 3 the UHB increased its savings target by £2m which in turn 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 confirmation of the month 5 position, the UHB undertook deep dives for all clinical boards to understand the issues and risks and gain assurance on the actions required to deliver within their deficit control totals. Further measures were approved to arrest and recover the financial run rate and the UHB's saving tracker is now reporting a £0.592m surplus of green and amber schemes against the £32m in year target. Year to date unplanned operational pressure are reported at £3.161m. The continuation of these additional costs and the and delivery of the remedial action and mitigation to recover the year to date pressures is now considered a risk to the plan.

The **forecast risk** in the plan is currently assessed at £1.000m as illustrated below (reported in £m):

Annual Savings Shortfall	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**	**3.52**	**(0.62)**	**(0.59)**	**(0.59)**	**(0.59)**	**(0.59)**	**(0.59)**	**(0.59)**
Cumulative Savings Shortfall/ (Surplus)	0.00	0.43	0.15	0.32	0.60	(0.04)	(2.08)	0.03	0.00	0.00	0.00	0.00	0.00
Forecast Cumulative Operational Pressures	0.00	(0.01)	0.24	0.09	0.60	2.00	3.10	(4.43)	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	0.00	0.00	(0.17)	(0.17)	(0.17)	(0.17)	(0.17)
Forecast Risk (Health Board gross forecast before recovery actions)	**23.00**	**5.19**	**3.99**	**3.69**	**5.42**	**6.43**	**5.40**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**

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 7, 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 & Recurrent Operational Pressures at month 7	8.000
Forecast Underlying Deficit (ULD) at end of 2025/26 without further identification of Savings & Actions	64.233

The underlying deficit will deteriorate further if the year to date and forecast operational pressures are not mitigated. In addition, any recurrent impact which materialises from the risks highlighted in respect of the Welsh Risk Pool and band 2 band 3 pay bands is likely to increase the underlying deficit.

The UHB is pressing for further recurrent schemes are being developed to close the gap.

The closing cash balance at the end of October was £4.773m.

Welsh Government has confirmed the 2025-26 Strategic Cash Requests submission date of Monday 8th December 2025. A separate paper will 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 £17m of working cash support to cover 2024/25 revenue and capital working balances which are expected to be paid in 2025/26.

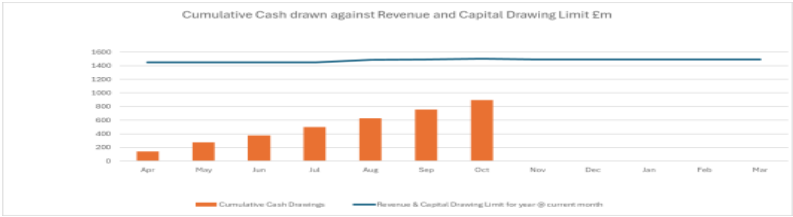
The value of unconfirmed drawing limit allocations at month 7 was £57m as outlined opposite. The outstanding confirmation of cash allocations is a cause for concern for the UHB, alongside the strategic and working cash requirement.

The table to the right summarises the potential for a £130.2m 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 October 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
Planned Care Insourcing	300
New Medical Training Posts 2017 to 2024	4,758
ATMPs (JCC)	3,100
Urgent & Emergency Care Fund	2,019
GP IM&T Refresh Programme	1,388
Consultant Clinical Excellence Award / Consultant Impact Award	1,480
RTT Waiting Times _Q1 Plans	1,225
Neurodivergence Improvement Programme	1,001
AWTCC Voluntary Scheme For Branded Medicines Pricing, Access And Growth (VPAG) Investm	793
DoIs / MCA/ Advocacy (MH)	593
Planned Care Transformation Fund	440
Individual Placement & Support In Primary Care	225
Genomics (C&V/ JCC	233
Women's Health - Pathfinder Establishment (Women's Health Hubs)	145
Welsh Risk Pool	(5,702)
Other	1,460
Total Anticipated Funding£'000s	**57,000**

Summary of Potential Cash Shortfall at Year End	£'000s
Outstanding allocations	57,000
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
Band 2/3 back pay and Welsh Risk Pool Risks (potential £17.594m)	tbc
Total £'000s	**130,233**



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 October was 96.2% for the year to date.

Capital

The UHBs approved capital resource limit is £38.381m in line with the latest Capital Resource Limit (CRL) received from Welsh Government on the 7th November 2025. This comprises of £14.317m discretionary funding , £22.943m towards specific projects (including Decarbonisation Funding, Lift Refurbishment and Pentyrch Surgery) and £1.121m relating to IFRS 16 lease capital funding.

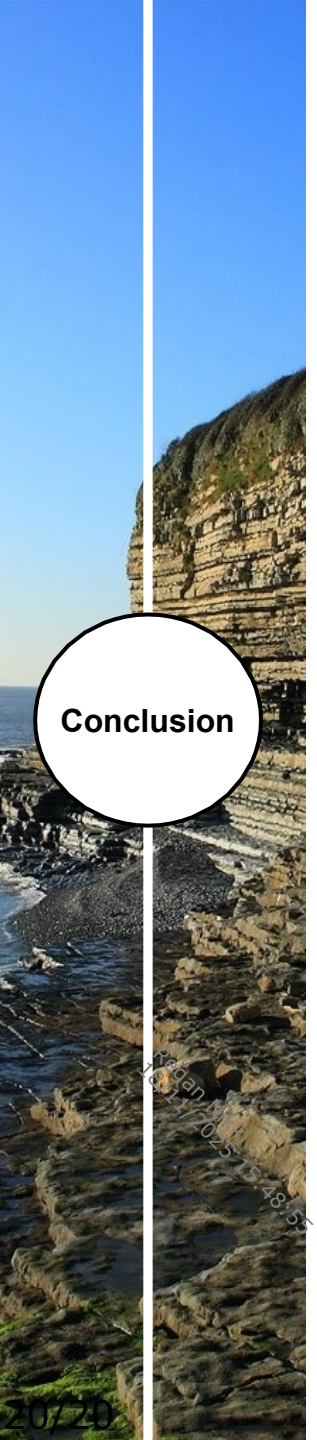
The capital programme is planned and monitored through the UHBs Capital Management Group (CMG) and the UHB forecasts that it will remain within its CRL in 2025-26.

As at Month 7, scheme slippage has been reviewed and identified in two schemes—Lift Refurbishment and Pentyrch Branch Surgery, which are now expected to underspend within the year. Consequently, CRL funding will be reduced and re-requested from Welsh Government for 2026/27.

A one-off VAT recovery was processed in Month 6 for various capital schemes, resulting in negative year-to-date expenditure figures for some schemes. A further VAT recovery of £1.5m for additional schemes has been added to the 7th November CRL, these are in addition to the M6 adjustments.

2025/26 Capital Programme (£m)	M7 Ytd			Annual	CRL	Plan vs CRL
	Actual	Revised Plan	Variance	Plan	7th Nov	
All Wales Schemes						
Electrical Infrastructure, Tertiary Tower Block at UHW	0.047	0.133	(0.086)	1.578	1.270	0.308
Lift Refurbishment and Upgrade, UHW	(0.383)	0.464	(0.847)	2.900	3.819	(0.919)
Decarbonsation funding - Solar Canopy Car Park	1.633	0.794	0.839	2.394	2.394	0.000
Pentyrch Branch Surgery Development 2024-26	0.751	1.035	(0.285)	3.955	4.735	(0.780)
Funding for Enabling Project Work – Cardiff & Vale UHB's Estate	0.217	0.265	(0.048)	0.277	0.277	0.000
TEF - Fire	0.072	0.096	(0.024)	0.876	0.876	(0.000)
TEF - Infrastructure	0.007	0.551	(0.544)	3.004	2.959	0.045
TEF - Decarbonisation	0.000	0.075	(0.075)	0.450	0.450	0.000
TEF - Mental Health	0.041	0.040	0.001	0.352	0.352	0.000
TEF - Infection Prevention Control	0.000	0.271	(0.271)	0.461	0.461	0.000
TEF - Decontamination	0.117	0.106	0.011	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
Radiology Equipment 2025-26	0.000	0.000	0.000	0.264	0.264	0.000
Hospital Helicopter Landing Site Schemes 2025-26	0.000	0.000	0.000	0.348	0.348	0.000
Haematology Day Centre Extension, University Hospital of Wales	0.000	0.000	0.000	2.666	2.666	0.000
DPIF						
DPIF - Medicines and Prescribing: Electronic Prescribing and Medicines	(0.026)	0.000	(0.026)	0.520	0.520	0.000
DPIF - RISP	(0.063)	0.000	(0.063)	0.632	0.632	0.000
VAT recovery	0.000	0.000	0.000	(1.500)	(1.500)	0.000
IFRS16	1.121	1.121	0.000	1.121	1.121	0.000
Discretionary						
IM&T:	0.766	0.998	(0.233)	2.094	0.500	1.594
Equip	0.370	0.320	0.051	1.000	1.000	0.000
Stat comp	1.229	1.194	0.035	2.600	2.800	(0.200)
Other	0.451	2.517	(2.066)	8.270	10.017	(1.747)
Total	6.350	9.980	(3.630)	36.682	38.381	(1.699)

Variances against the CRL for individual All Wales schemes, excluding the noted slippage, are being managed within the discretionary capital allocation and have been agreed as part of the draft programme. All schemes are expected to broadly deliver within the financial 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 7 position is £2.816m above plan primarily due to unplanned operational pressures of £3.162m at month 7.

At Month 7 the Committee are requested to:

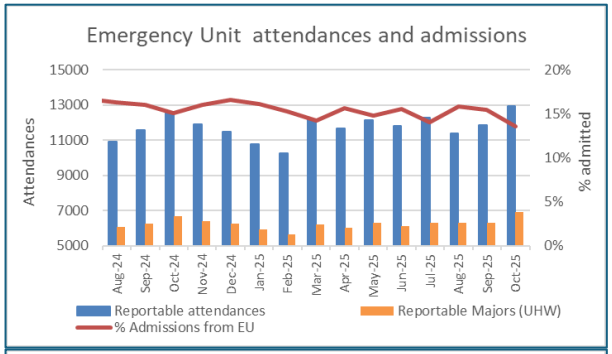
- **NOTE** the reported year to date position is an overspend of £35.619m and the forecast deficit of £56.2m.
- **NOTE** the month 7 operational overspend against plan of £3.162m and the (£0.346m) savings surplus.
- **NOTE** the progress against the savings target, with £32.592m (101.9%) of green and amber schemes identified at Month 7 against the revised £32m target.
- **NOTE** that delivery of the forecast is predicated on delivery of recovery actions and the confirmation of all expected income streams.
- **NOTE** the recurrent savings shortfall and recurrent operational pressures of £8.000m impacting adversely on a deteriorating underlying deficit being carried into 2026/27
- **NOTE** there is a potential £130.2m cash shortfall at year end before outstanding cash allocations and strategic support are confirmed by Welsh Government.

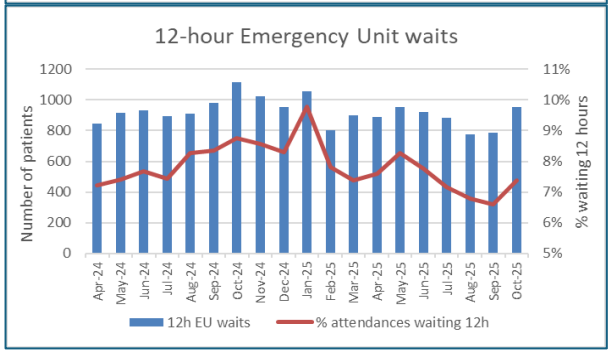
CARDIFF & VALE UHB
OPERATIONAL PERFORMANCE REPORT
– November 2025

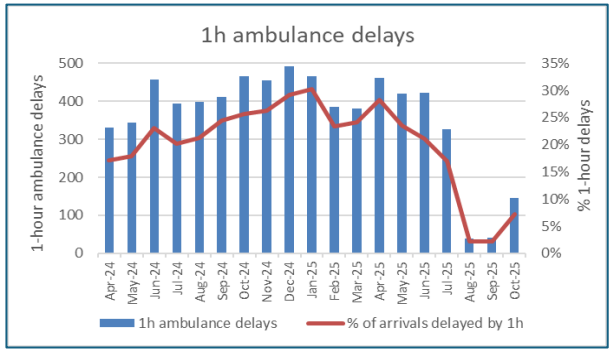

Urgent and Emergency Care
Out of hospital and EU
Flow and discharge
Planned Care
Primary and Community
Mental Health
Productivity and efficiency

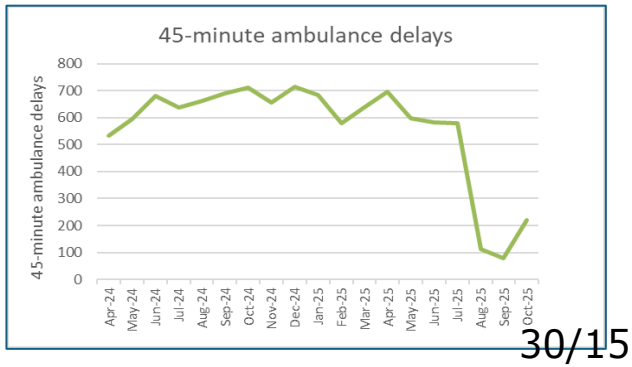
Urgent and Emergency Care – Out of Hospital and Front Door

- In October attendances at the Emergency Unit increased from those in September and were increased by around 2.5% compared to October '24. The number of Majors attendances was increased from September '25. The proportion of patients admitted via EU reduced to 13.6% and is reduced when compared to October '24
- We have seen a 3.6% increase in demand over the last 12 month, against a forecast of 4%. This is putting pressure on EU as we move into winter
- Following periods of intense operational pressure, the number of patients wating 12 hours or more in EU increased and the proportion of attendances resulting in a 12 hour wait increased to 7.4%. The number of patients waiting 24 hours in the EU footprint was 36, with over half those coming in the last 3 days of the month
- The number of 1-hour ambulance holds increased in October – c7% of conveyances waited >1h at UHW. In line with the Ministerial Advisory Group recommendations, we have moved our operational focus to reducing and eliminating 45-minute ambulance holds. This has included ringfencing majors capacity to facilitate timely handovers. Operational pressure in month led to an increase in 45-minute holds, but performance remains improved from the summer



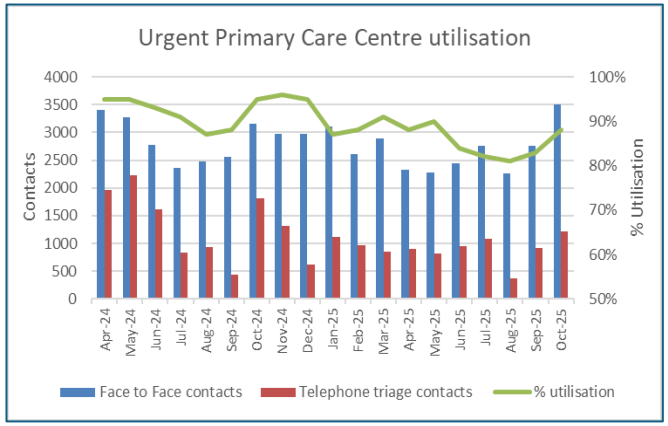




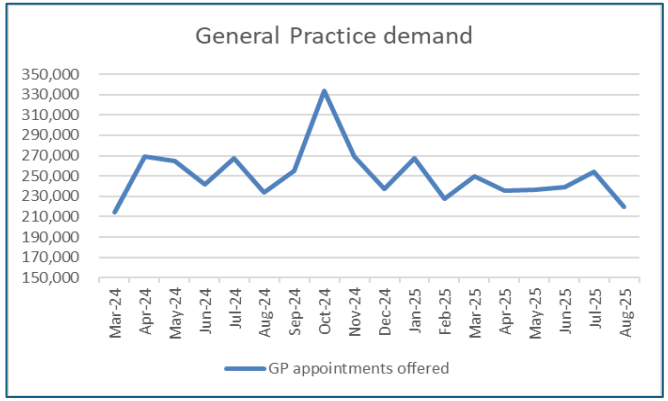


Urgent and Emergency Care – Out of Hospital and Front Door

- In October, 3,498 patients attended Urgent Primary Care Centres across Cardiff and the Vale, with a further 1219 patients triaged by telephone. In October 88% of the available slots were utilised, increased from September
- In 24/25 there were over 4.5 million calls to GP surgeries, with over 3.1 million appointments offered. So far this year over 1 million appointments have been offered across Cardiff and the Vale, fewer than as this point last year
- Calls to surgeries has seen a downward trend over the past 3-years, while digital requests have increased
- The number of appointments offered in August reduced from the previous month
- We continue to see pressure across GMS with our primary care team supporting practices where required



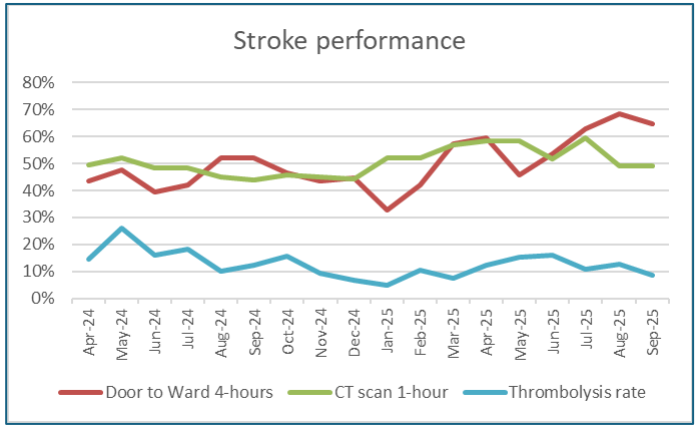
GMS activity	August 2025	Year to date 25/26
Calls to GP surgeries	283,572	1,552,023
Digital requests to GP practices	76,901	380,914
GP appointments offered	219,901	1,184,874
Items issued via presciption	711,771	3,649,929



Urgent and Emergency Care – Hospital Flow and Discharge

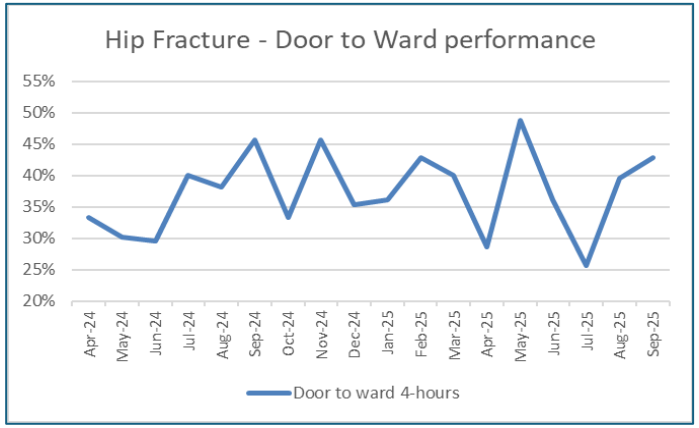
Stroke

- The most recent data from September showed a small drop in compliance with the Door to Ward standard for Stroke patients. Compliance fell from 68.4% to 64.8%. In September 49.2% of patients receiving their CT scan within 1-hour, the same as August



Hip fracture

- In September, 42.9% of Hip Fracture patients were admitted to the ward within 4-hours. This represents an increase in performance from August and remains significantly above the national average of 9.6%

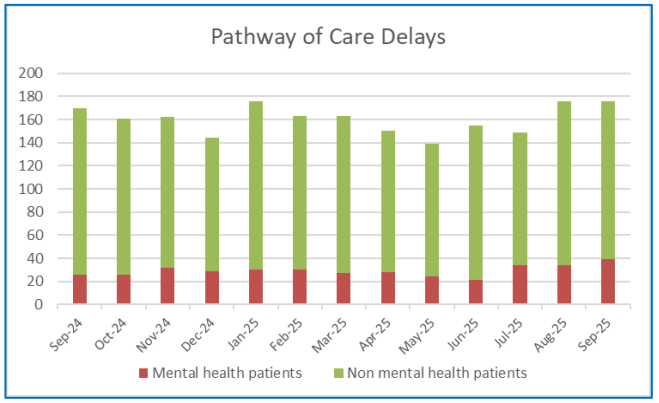


Urgent and Emergency Care – Hospital Flow and Discharge

- Pathway of Care Delays remained steady in October at 177, the number of non-Mental Health delays increased to 142 with an average length of stay since becoming clinically optimised of 40.3 days. Mental Health delays reduced to 35, with an average length of stay since becoming clinically optimised of 116 days. 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. In total 9,793 beds days were lost in October.

- In partnership with out Local Authority colleagues, we are taking the following actions:

  - Delivering the trusted assessor model
  - Named social worker for medical wards in UHL
  - Forensic review of patients who've stayed >10 days
  - Check and challenge in our community hospitals by GPs and community clinicians
  - Daily touch points with Cardiff and VoG Local Authorities
  - Reviewing 'reason for attendance'
  - Forensic review of all non-clinically optimised patients

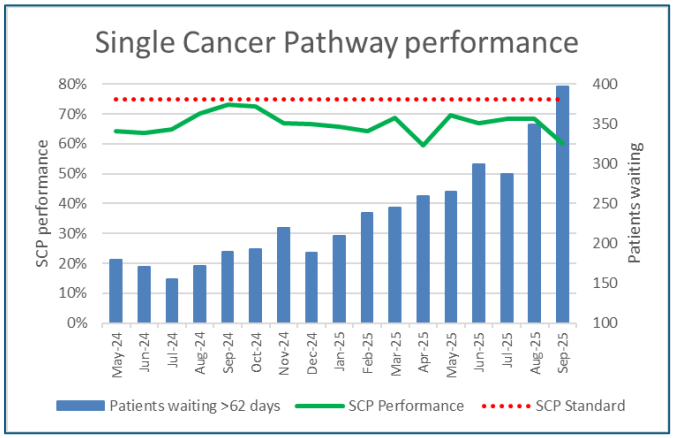


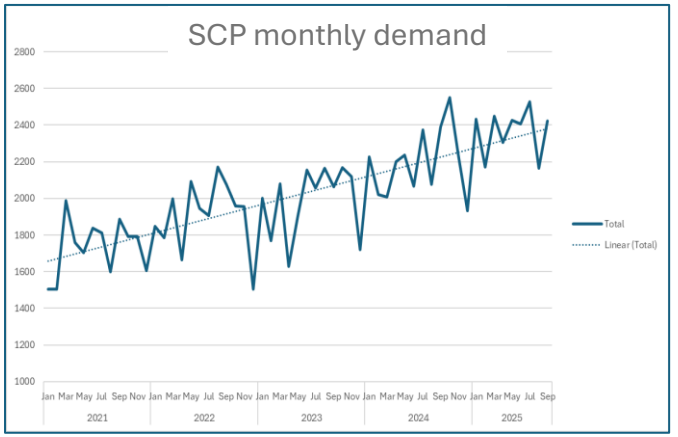
Top 6 Reasons for non- MH	Number of Delays
Awaiting completion of assessment by social worker	36
Awaiting social worker allocation	16
Awaiting start of new care package funding by social care	11
Mental Capacity Assessment delays	10
Awaiting joint assessment	8
Awaiting completion of best interest	8

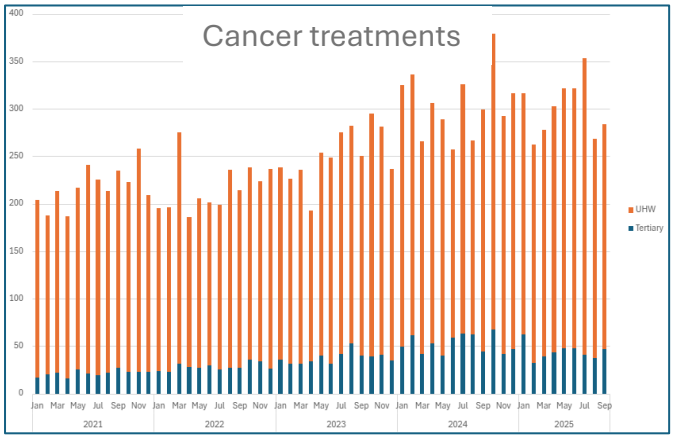
Top 6 Reasons for MH Delays	Number of Delays
Awaiting dementia nursing availability	5
Awaiting care home manager visit assessment and provide outcome (nursing)	4
Awaiting funding decision	3
Awaiting funding decision FNC/CHC	3
Identifying specialist bed	3
Awaiting supported living availability	3

Planned Care, Cancer and Diagnostics

- Performance against the Single Cancer Pathway dropped in September to 60.2%
- We have seen an increase in the number of patients waiting over 62 days for treatment. SCP compliance will remain reduced as we treat longer waiting patients to reduce the backlog
- We continue to see increasing referrals onto the SCP and while treatments per month have also increased, we face a challenge to maintain our improved SCP performance and deliver the 75% standard
- We have seen a 38% increase in referrals to the SCP in the past 3 years. In 2022 we treated c190 C&V patients per month, this has increased to c250 in 2025
- Our forecast dip in compliance is mainly related to challenges in 3 tumour sites. We have identified, through pathway and breach analysis, the main causes of delays and developed actions :







Planned Care, Cancer and Diagnostics

– Skin

- Skin demand has been rising at the fastest rate of any tumour site and demand in 2025 has been 8% higher than last year
- The major cause of the increase in backlog for skin patients is the increase in wait for a first outpatient appointment.
- Additional OP slots have been allocated in November through WLI and use of non-cancer clinic capacity
- Longer term actions include recruitment of 2 consultants (from January) and use of patient initiated FUs for SCC in line with national guidance
- October has seen a drop in demand and with the actions outlined we forecast compliance to return to >90% by January 2026

– Urology

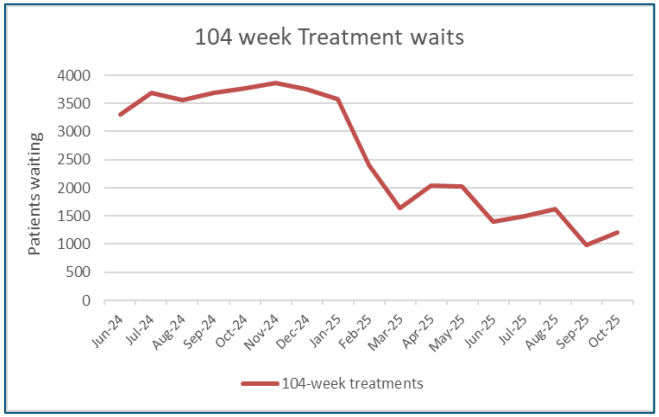
- The backlog in Urology has been growing since October 2024
- Demand in 2025 is 14% higher than in 2024
- Treatment volumes have increased between 6-8% since April 2024
- Urology consistently sees the highest volume of breaches - recently this has accounted for 1/3 of all breaches
- Prostate makes up the majority of these breaches – with TP biopsy the most frequent cause of delay
- Plan to use SSSU lists and SAS/Consultant time to reduce TP waits to 1 week would see SCP compliance improve to 70% by May 2026

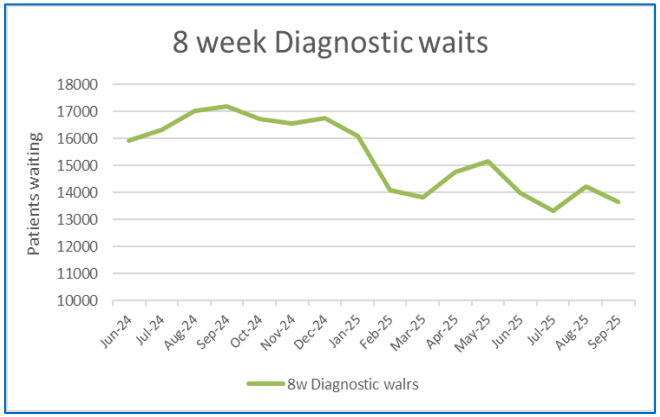
– Lower GI

- The backlog in lower GI has been increasing since October 2024
- Tracking data shows and breach analysis shows most breaches are associated with Endoscopy and Bowel Screening Wales
- Time to surgery has been identified as the main cause of Endoscopy delays – plans are being developed to provide 1 additional theatre list per week to bring this back into balance

Planned Care, Cancer and Diagnostics

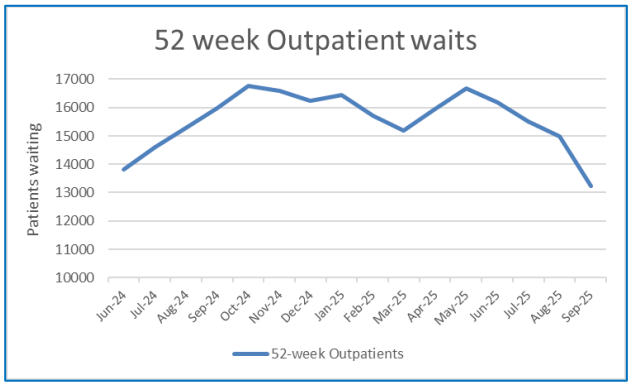
- Following delivery of our Q2 commitment to reduce 2- year waits, the number of patients waiting 2-years for treatment increased in October as forecast to 1202. We are working on delivering our commitment to deliver a reduced position of 630 at the end of Q3. We are currently on trajectory to deliver this. Even with additional funding we are currently unable to eliminate 2-year waits for sleep studies or spinal surgery by the end of the year. The waiting list is tracked daily, with weekly updates to the COO, CEO and Chair
- Diagnostic 8-week waits reduced in September 2025 to 13,667, mainly driven by reductions in endoscopy and NOUS waits. The MRI and CT positions increased but this will be recovered with additional capacity in Q3 and Q4.
- A verbal update will be given at the meeting on the formal October position – we expect to see a further reduction driven by continued improvements to Endoscopy and NOUS. We have also seen small improvements for MRI and CT as we begin to recover their positions

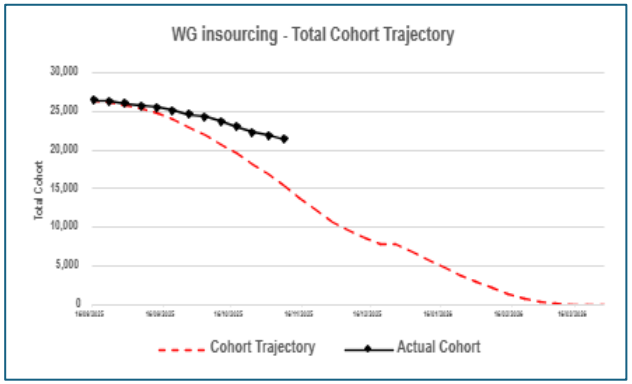


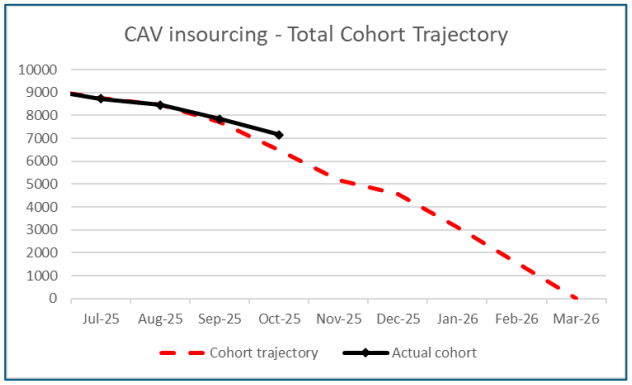


Planned Care, Cancer and Diagnostics

- The number of patients waiting 52-weeks for an outpatient appointment reduced in September 2025 driven mainly by surgical specialties. October's position will be updated at the meeting. We are anticipating further improvement in line with the outpatient work below
- We are working closely with Welsh Government on national schemes to undertake c33,000 additional outpatient appointments through this year
- To date we have delivered c4200 appointments through the Government insourcing contract and over 1300 appointments through C&V schemes
- We hold weekly senior meetings with HBS (WG insourcing provider) – while we are off trajectory, robust improvement trajectories are in place to recover the position. Main risk areas are oral surgery and dermatology – the contract has been reviewed in line with our core delivery model to allow clinicians to be onboarded

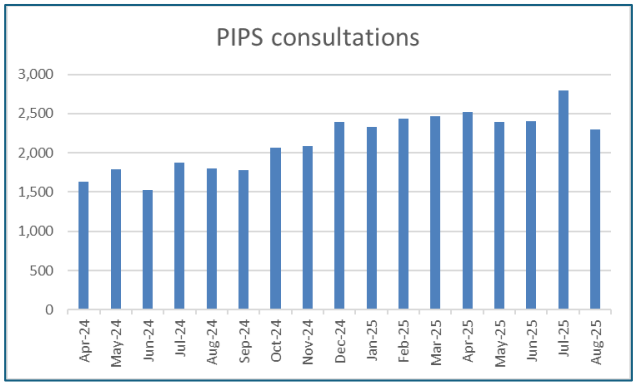


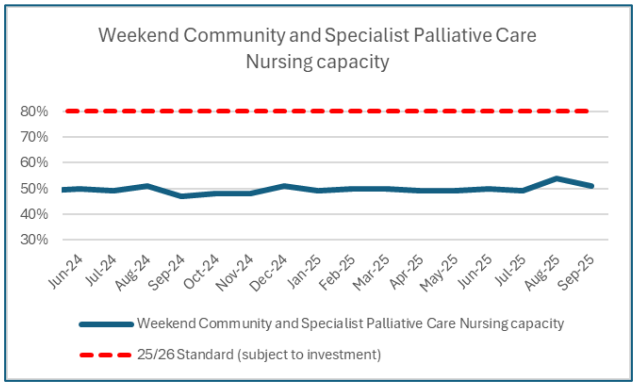


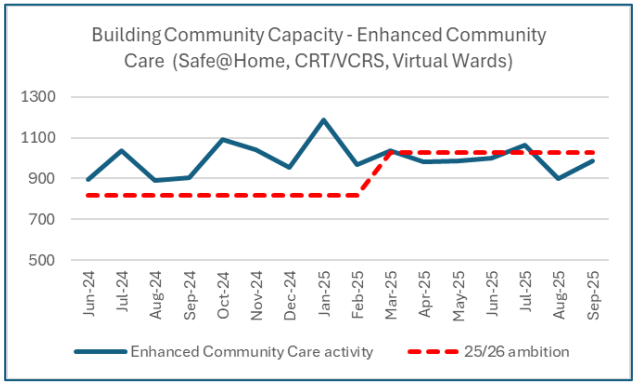


Primary and Community Care

- 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 Q2 25/26
- Community Pharmacy continues to develop the Pharmacist Independent Prescribing Service, with 2,299 consultations delivered in August 2025, increased from the August last year
- 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. Activity dropped as forecast in August, with annual leave and reduced demand but increased in September

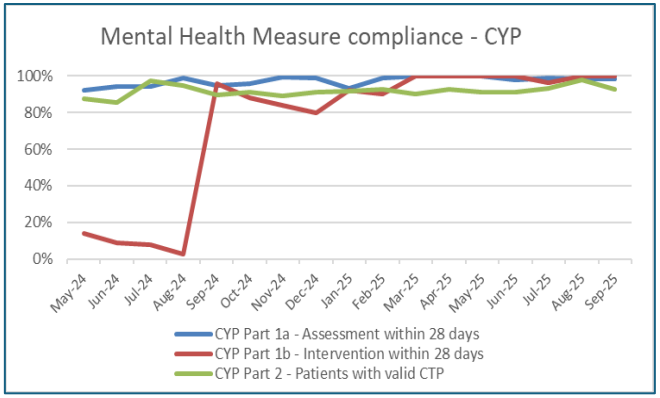


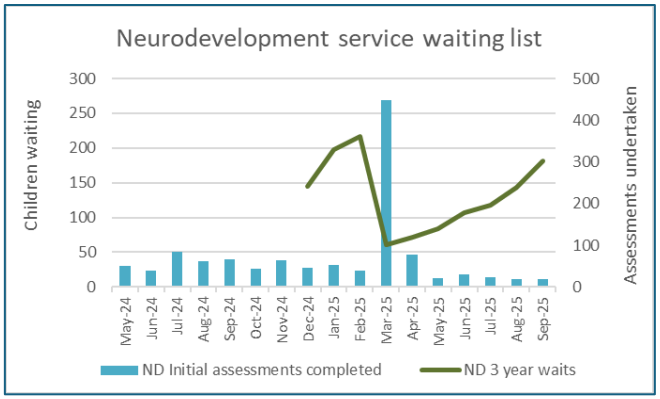


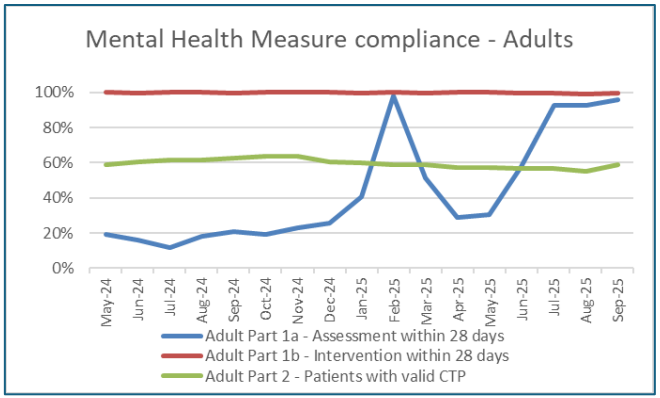


Mental Health

- For Children and Young People, Part 1a and 1b remain compliant despite high demand, >98% compliance reported for September 2025. Part 2 performance also remains compliant, with over 90% compliance maintained throughout 2025
- The Neurodevelopment service waiting list continues to grow with 213 referrals in September. 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 181 in September. In total there are 4,820 children on the waiting list for assessment
- For Adult and older people's mental health services, September saw Part 1a compliance maintained over 95%, despite referrals remaining high. Part 1b remains compliant with 99.6% reported in September. Part 2 compliance remained low despite ongoing actions. The health board has developed an improvement trajectory with the clinical teams over a 5-month period. This approach has been shared and agreed with NHS Performance and Improvement





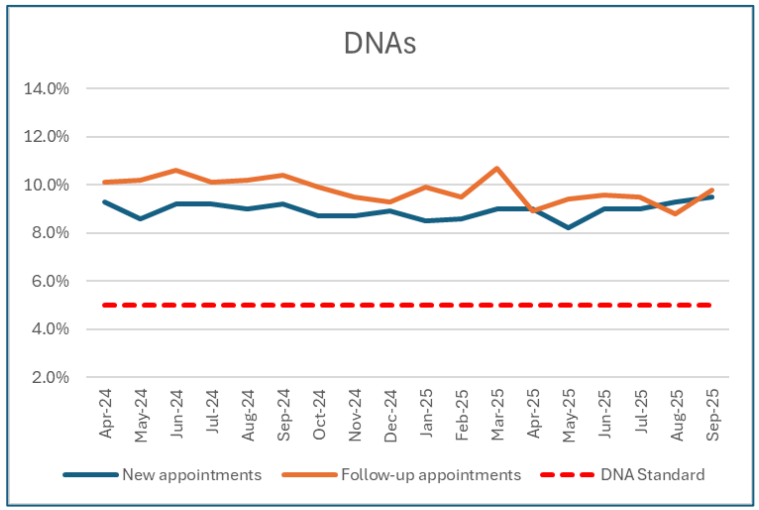


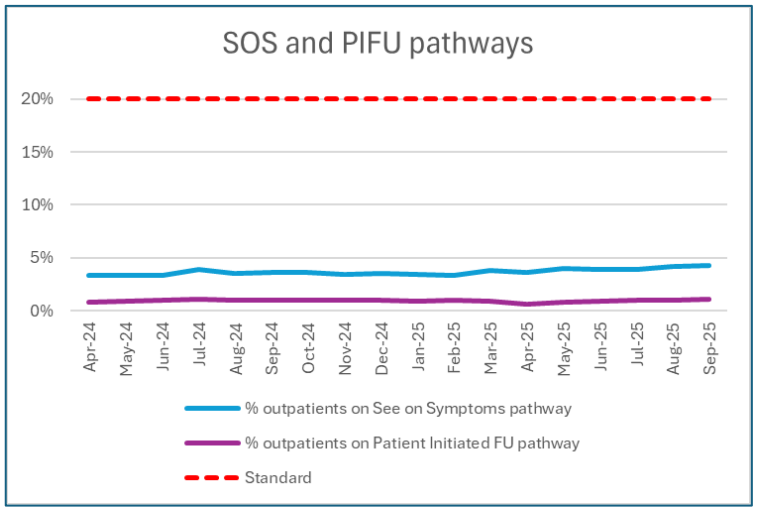
Mental Health Measures:
1a – assessments undertaken within 28 days
1b – therapeutic interventions undertaken within 28 days following assessment
2 – residents with a valid health and care treatment plan

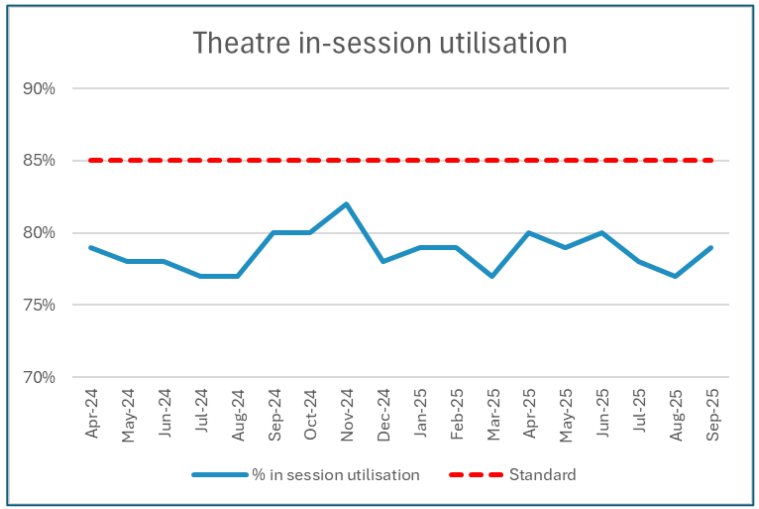
Productivity and Efficiency

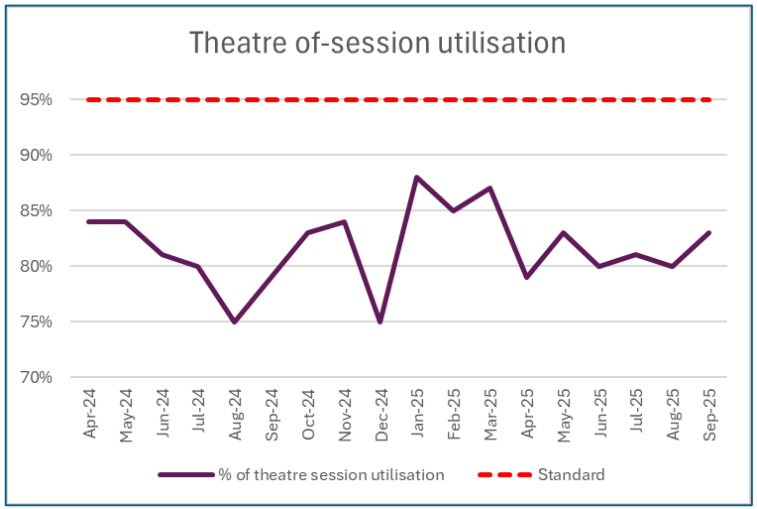
Measure		Standard	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Trend
Outpatients	% DNAs - New appointments	5%	9.2%	8.7%	8.7%	8.9%	8.5%	8.6%	9.0%	9.0%	8.2%	9.0%	9.0%	9.3%	9.5%	
	% DNAs - Follow-up appointments	5%	10.4%	9.9%	9.5%	9.3%	9.9%	9.5%	10.7%	8.9%	9.4%	9.6%	9.5%	8.8%	9.8%	
	% outpatients on See on Symptoms pathway	20%	3.6%	3.6%	6.6%	3.5%	3.4%	3.3%	3.8%	3.6%	4.0%	3.9%	3.9%	4.2%	4.1%	
	% outpatients on Patient Initiated FU pathway		1.0%	1.0%	1.0%	1.0%	0.9%	1.0%	0.9%	0.6%	0.8%	0.9%	1.0%	1.0%	1.1%	
Endoscopy	% room utilisation	90%	74%	68%	78%	75%	83%	82%	88%	78%	88%	81%	87%	71%	72%	
	% utilisation (activity points available)	95%	83%	85%	87%	85%	84%	81%	84%	87%	89%	87%	90%	89%	87%	
Theatres	Average turnaround time (minutes)	10	18.9	19.9	15.9	16.2	15.9	18.2	17.1	16.6	15.9	17.5	17.0	16.8	18.1	
	% of theatre session utilisation	95%	79%	83%	84%	75%	88%	85%	87%	79%	83%	80%	81%	80%	83%	
	% in session utilisation	85%	80%	80%	82%	78%	79%	79%	77%	80%	79%	80%	78%	77%	79%	
	<24 hour elective cancellations	N/A	190	363	198	217	315	295	347	237	229	281	287	220	238	
Waiting list	Total RTT waiting list volume	N/A	155,063	156,194	154,994	154,605	153,519	151,069	151,226	152,150	152,901	151,955	150,902	150,551	150,553	
Inpatient	Delayed pathways of Care - Mental Health	217	26	26	32	29	30	30	27	28	24	21	34	34	39	
	Delayed Pathways of Care - non-Mental Health		144	135	130	115	146	133	136	122	115	134	115	142	137	
	7 day LOS on Acute Wards (snapshot)	<40%	58.5%	59.4%	57.3%	62.3%	60.5%	59.4%	56.2%	57.8%	61.0%	59.3%	56.9%	57.7%	54.4%	
	21 day LOS on Acute Wards (snapshot)	<20%	31.8%	31.4%	30.9%	35.5%	37.3%	34.0%	34.0%	33.4%	33.4%	32.3%	32.0%	32.4%	29.4%	
	Medicine (all services) non-elective LOS (on discharge)	N/A	11.9	10.7	10.4	10.5	9.8	12.4	11.0	10.3	11.9	9.8	10.9	9.7	9.2	
Urgent and Emergency	Reportable attendances	N/A	11,567	12,628	11,922	11,468	10,756	10,237	12,193	11,659	11,517	11,823	12,304	11,398	11,880	
	Reportable Majors attendances	N/A	6,235	6,691	6,398	6,272	5,924	5,628	6,210	6,041	6,297	6,113	6,295	6,291	6,308	
	Reportable EU admissions	N/A	1,768	1,823	1,831	1,829	1,676	1,502	1,658	1,754	1,708	1,757	1,733	1,805	1,839	
	SDEC attendances	N/A	1,730	1,847	1,716	1,601	1,786	1,609	1,770	1,678	1,779	1,753	1,908	1,676	1,807	

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

November 2025

Report Contents

Click on a hyperlink to navigate directly to the section required

Section 1: Cabinet Secretary Priorities

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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

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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**	**177** Oct-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**	**2,299** Aug-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**	**51%** Sept-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**	**988** Sept-25	Hyperlink to section

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

Section 1: Cabinet Secretary Priorities

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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	45.6% Aug-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	98.6% Sep-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	95.9% Sep-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% Sep-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	99.6% Sep-25	Hyperlink to section

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

Section 1: Cabinet Secretary Priorities

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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**	**146** Oct-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**	**949** Oct-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**	**981** Sept-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**	**60.2%** Sept-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**	**13,667** Sept-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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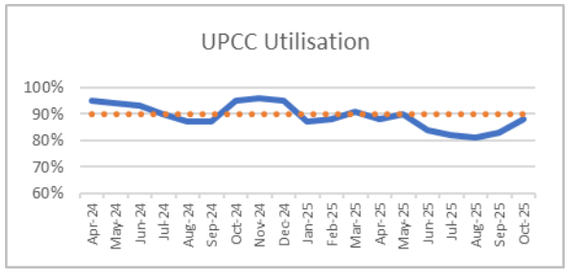
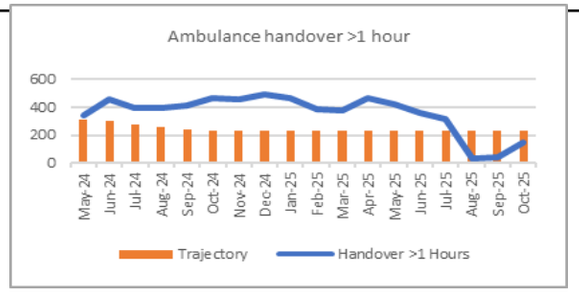
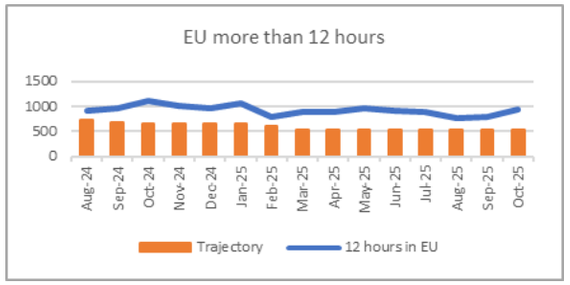
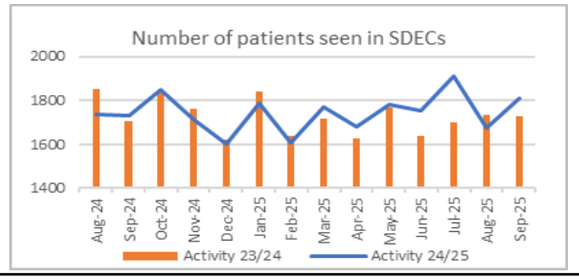
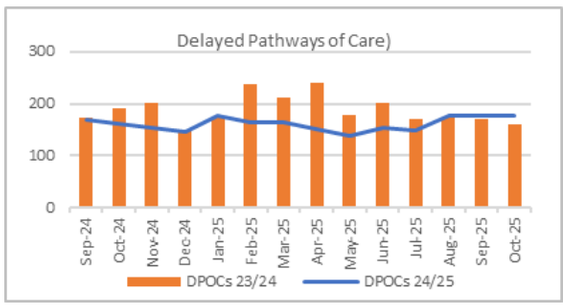
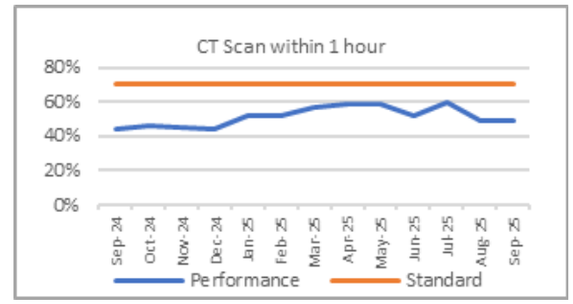
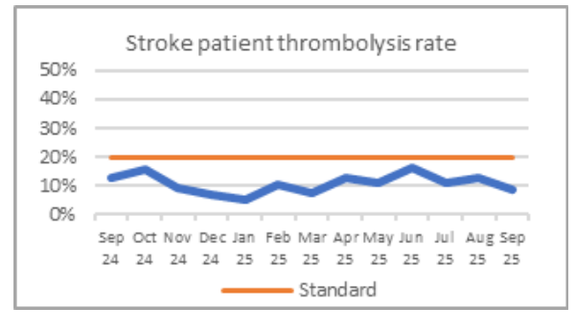
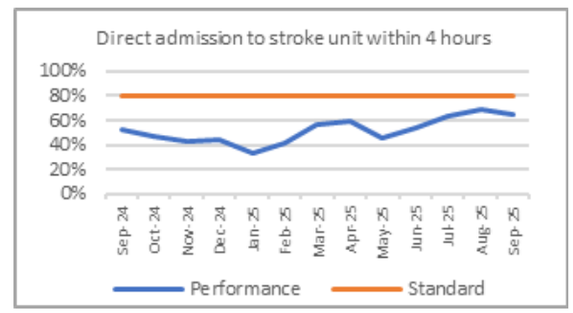
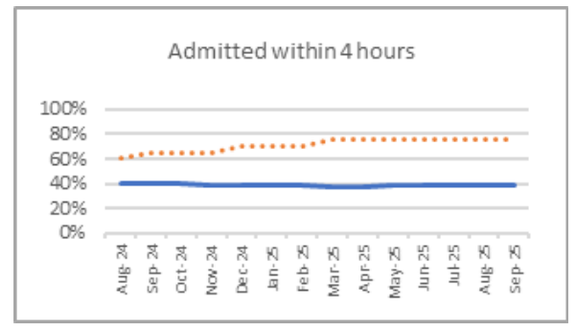
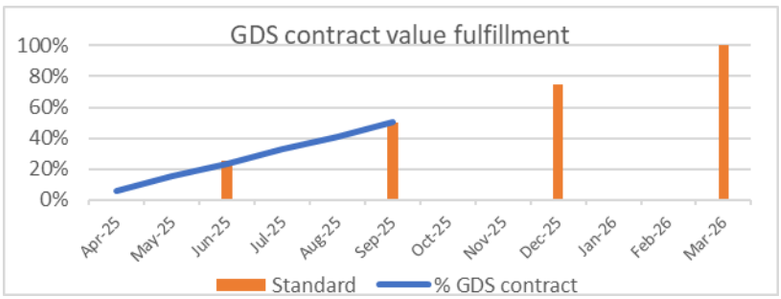
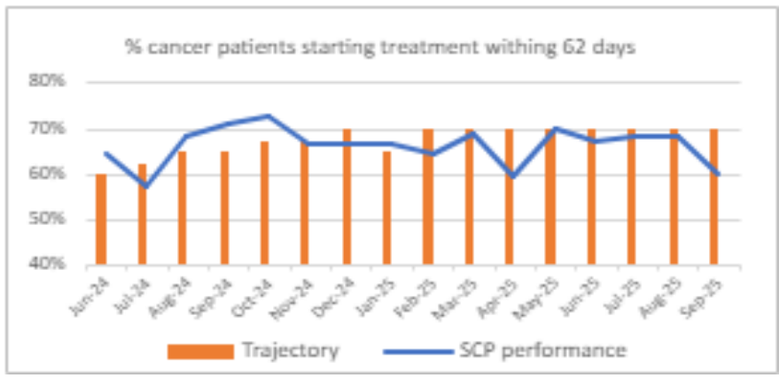
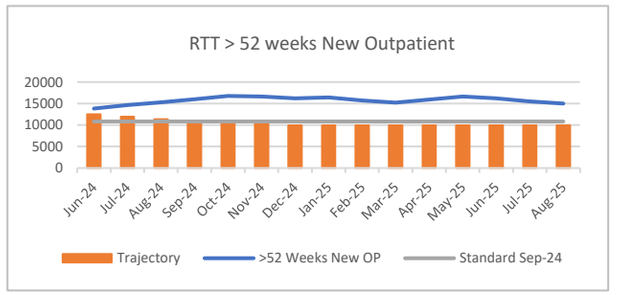
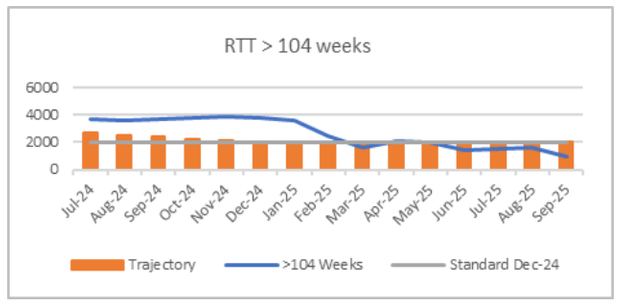
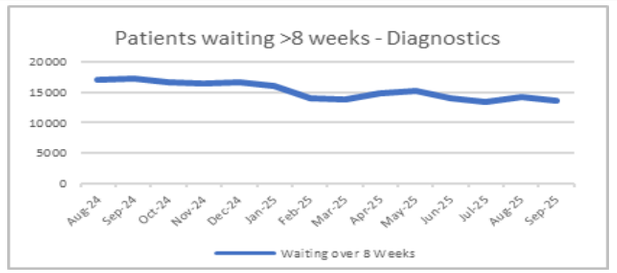
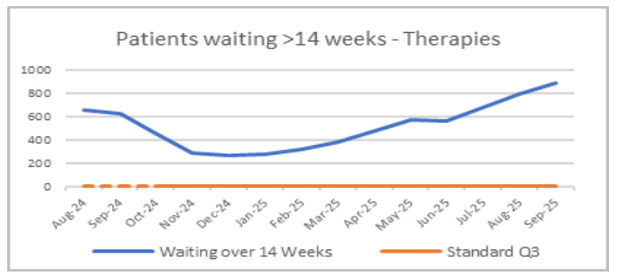
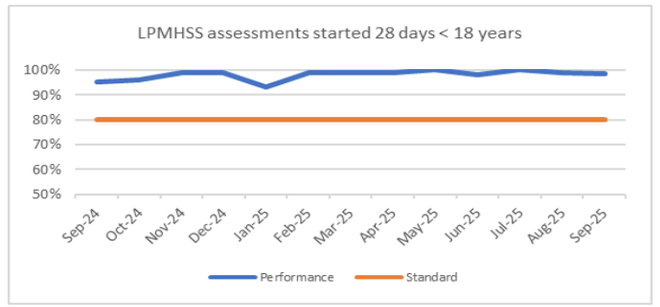
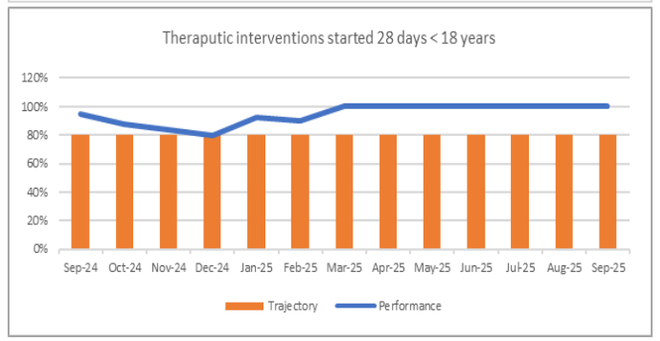
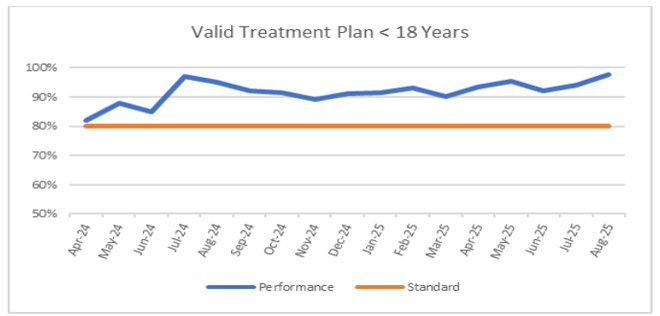
Number	Aim	Contents
Aim 1	People in Wales have improved health and well-being with better prevention and self-management	Public Health
Aim 2	People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement	Urgent and Emergency Care 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

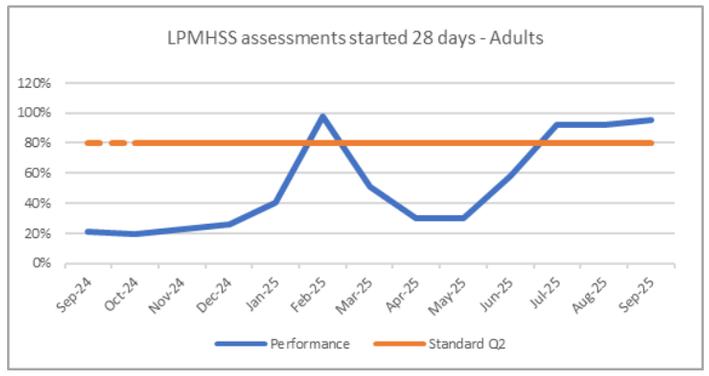
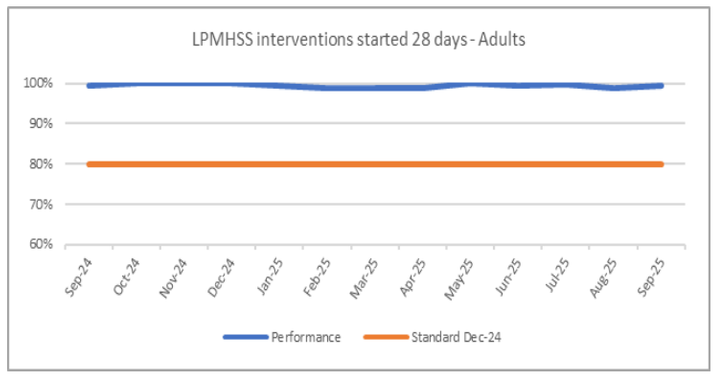
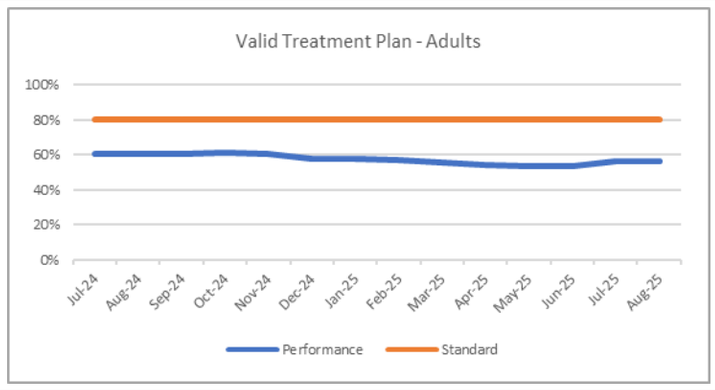
Priority	Performance Summary	Reporting Period	Performance against standard	Data
Primary, Community and Out of Hospital Care	**Urgent Primary Care Centre Utilisation – Maintain 90% utilisation** In October utilisation was 88%, this is below our commitment. We have made changes to the model, combining face to face consultations and use of the triage service within the reporting **Community visits – 95% of face-to-face visits within 8 hours** Q1 to date 94% compliance with 8-hour standard	Oct-25 Aug-25	88% utilisation Below standard 94% Below 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 October we reported 46 2-hour ambulance delays, through a period of intense operational pressure at the end of the month. In October we reported 146 1-hour ambulance delays, an increase from August but below our commitment of <365 In October lost minutes per arrival increased to 13, this is still a significant improvement since the summer reflecting the implementation of the W45 protocols as discussed in the accompanying paper **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 October we reported an increase in patients waiting 12-hours in EU compared to September. This equates to 92.7% of attendances waiting less than 12-hours and below our ambition for Q4, but an improvement from the previous month **SDEC units** In September we reported an increase in activity compared to August, and increased from September 2024 activity.	Oct-25 Oct-25 Sep-25	46 2-hour delays Above standard 146 1-hour delays Below standard 13 minutes lost/arrival Above standard 92.7% patients <12h Below standard 1807 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 October 56.7% of patients in acute beds had a LOS of >7 days, 29.5% >21 days – a deterioration from September. See paper for POCD update **Pathway of Care Delays – <160 delayed patients each month** In October 2025 the number of POCDs was 177 – this is similar to August and September – actions undertaken with local authority partners are detailed in the paper	Sept-25 Oct-25	54.4% >7d Above standard 29.4% >21d Above standard 177 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 September 49.2% of patients were received their CT scan within 1 hour of arrival at EU, the same as August **Thrombolysis – 20% thrombolysis rate** In September 8.5 % of stroke patients were thrombolysed, reduced from August. 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 September 64.8% of patients were admitted directly to the Stroke Unit within 4 hours. Door-to-ward compliance has improved despite pathways continuing 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 recruitment has taken place to embed changes to the acute pathway 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	Sep-25	49.2% CT Below standard 8.5% Thrombolysis Below standard 64.8% 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 September our annualised compliance showed 38.0% of patients were admitted to the ward within 4 hours. This is below our ambition but well above the national average of 9.6%.	Sep-25	38.0% (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 June 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 September) 50.2% of the contract value has been delivered **Pharmacy access – >2185 accessing Pharmacy Independent Prescriber service** In July 100% of practices were providing CCPS services, providing 2,797 consultations **Optometry – 95% of practices providing WGOS1+2** All practices are currently providing WGOS 1&2	Sep-25 Jul-25	100% At standard 50.2% At standard (Apr-25 – Sep-25) 2,299 Above standard 100% Above standard	
Cancer	**Single Cancer Pathway – 75% of patients to receive their first definitive treatment within 62 days by Q4** In September 60.2% 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. More detail is discussed in the accompanying paper	Sept-25	60.2% 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 September there were 13,617 patients waiting 52 weeks for their first outpatient appointment. This is improved from August, additional actions are outlined in the cover paper **Treatment waiting times – Reduction in the number of patients waiting 104 weeks for treatment** In September there were 981 patients waiting 104 weeks for treatment. This is reduced from August and delivers the trajectory shared with Welsh Government. Our October data has not been released at the time of producing this report – a verbal update will be provided at the meeting	Sept-25	13,617 patients Above standard 981 patients Below standard (Q2)	 
Diagnostics and Therapies	**Diagnostics – Reduction in the number of patients waiting over 8 weeks for a specified diagnostic** In September 13,667 patients were waiting over 8 weeks for a specified diagnostic, A reduction from August. Improvement in the radiology position this month, with NOUS waits also notably reduced. **Therapies – National standard of zero 14 week waits** In September 894 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. We are in discussions with Welsh Government about solutions to reduce therapy waits across our services	Sept-25	13,667 patients Diagnostics Above standard 894 patients Therapies Above standard	 

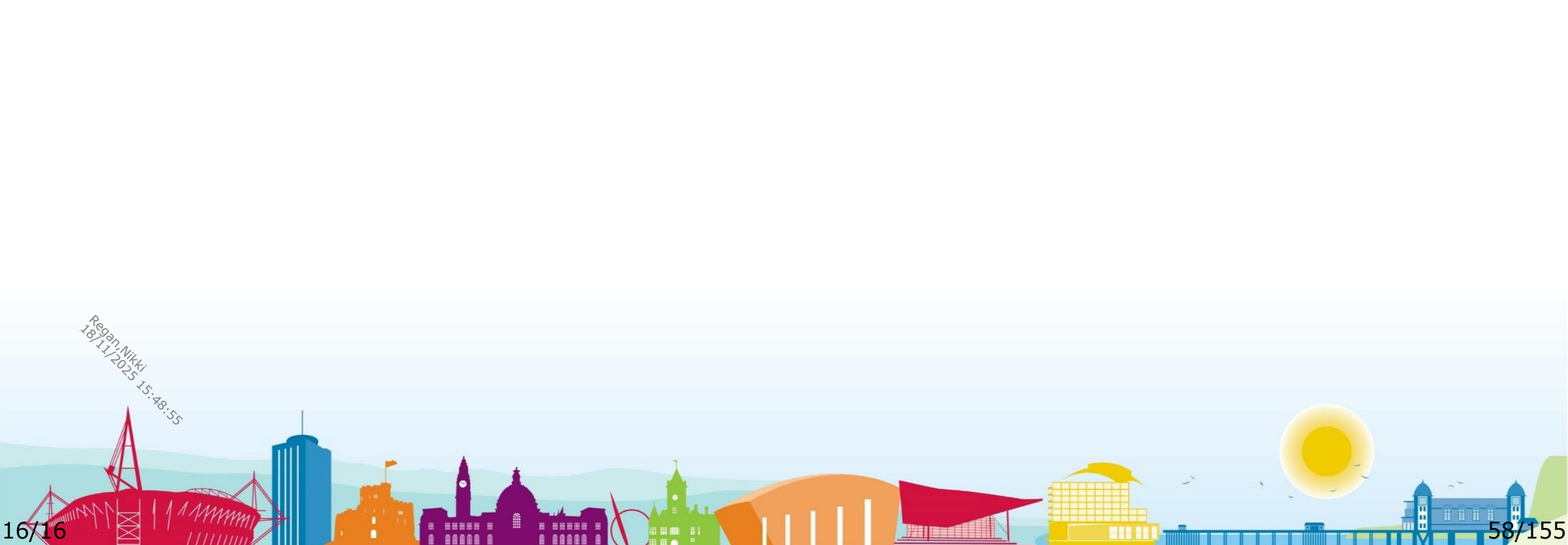
Priority	Performance Summary	Reporting Period	Performance against standard	Data
Paediatric waiting times	**New Outpatient waits – 0 patients waiting over 52 weeks for outpatients in Q1** In September there were 0 patients waiting over 52 weeks for a new outpatient appointment	Sept-25	0 Meeting standard	
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 September 98.6% of assessments were completed within 28 days		98.6% 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 September 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	Sep-25	100% Part 1b Above standard	
	Percentage of patients with a valid Care and Treatment plan – 80% compliance with standard In September 92.5% of patients had a valid Care and Treatment Plan, above our ambition		92.5% 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 September 95.9% of patients received their assessment within 28 days. Referrals to the service remain high.	Sep-25	95.9% 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 September 99.6% of therapeutic interventions were started within 28 days of assessment, above the standard and in line with our trajectory submitted to Welsh Government.	Sep-25	99.6% Part 1b Above standard	
Mental Health Measures – Part 2	**Percentage of patients with a valid Care and Treatment plan – 80% compliance with standard** In September 58.6% of patients had a valid Care and Treatment plan, a small decrease from July. 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. Additional information is provided in the paper	Aug-25	58.6% 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	Sep-25	Improvement compared to the same month in the previous year	**45.3%** Above standard	Jun-25: 46.1% | Jul-25: 46.0% | Aug-25: 45.6% | Sep-25: 45.3%
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 - Sep-25	A month on month increase towards a minimum of 30% contract value delivered by 30 September 2024 and 100% by 31 March 2025	**50.2%** Above standard	Apr-25 - Jun-25: 23.4% | Apr-25 - Jul-25: 32.8% | Apr-25 - Aug-25: 40.8% | Apr-25 - Sep-25: 50.2%
14.	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Aug-25	Increase compared to the same month in the previous year	**2299** Above standard	May-25: 2388 | Jun-25: 2398 | Jul-25: 2797 | Aug-25: 2299
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	Sep-25	80%	**98.6%** Above standard	Jun-25: 97.8% | Jul-25: 99.0% | Aug-25: 99.0% | Sep-25: 98.6%
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	Sep-25	80%	**100%** Above standard	Jun-25: 100% | Jul-25: 96% | Aug-25: 100% | Sep-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	Sep-25	80%	**95.9%** Above standard	Jun-25: 57.9% | Jul-25: 92.0% | Aug-25: 92.5% | Sep-25: 95.9%
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	Sep-25	80%	**99.6%** Above standard	Jun-25: 99.5% | Jul-25: 99.6% | Aug-25: 99.0% | Sep-25: 99.6%
19	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes – WAST response to red calls has been reviewed and they are no longer reporting this metric	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	Aug-25	12 month reduction trend	**01:26:17** Above standard	May-25: 01:19:34 | Jun-25: 01:34:20 | Jul-25: 01:27:34 | Aug-25: 01:26:17

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	Aug-25	15 minutes or less	**5** Below standard	May-25: 6; Jun-25: 6; Jul-25: 5; Aug-25: 5
22.	Median time from arrival at an emergency department to assessment by a clinical decision maker	Aug-25	60 minutes or less	**71** Above standard	May-25: 64; Jun-25: 68; Jul-25: 65; Aug-25: 71
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	Oct-25	Improvement compared to the same month in the previous year, towards the national target of 95%	**60.1%** Below standard	Jul-25: 65.5%; Aug-25: 61.5%; Sep-25: 59.7%; Oct-25: 60.1%
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	Oct-25	Reduction compared to the same month in the previous year, towards the national target of zero	**949** Above standard	Jul-25: 883; Aug-25: 774; Sep-25: 785; Oct-25: 949
25.	Percentage of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Aug-25	12 month improvement trend towards a national target of 80% by 31 March 2026	**68.4%** Below standard	May-25: 69.6%; Jun-25: 67.0%; Jul-25: 68.4%; Aug-25: 68.4%
26.	Number of patients waiting more than 8 weeks for a specified diagnostic	Sep-25	0	**13,667** Above standard	Jun-25: 14007; Jul-25: 13344; Aug-25: 14243; Sep-25: 13667
27.	Percentage of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional therapy	Sep-25	100%	**61.1%** Below standard	Jun-25: 71.83%; Jul-25: 68.37%; Aug-25: 65.20%; Sep-25: 61.13%
28.	Number of patients (all ages) waiting more than 14 weeks for a specified therapy	Sept-25	0	**894** Above standard	Jun-25: 556; Jul-25: 681; Aug-25: 797; Sep-25: 894
29.	Number of patients (all ages) waiting more than 14 weeks for audiology	Sep-25	0	**1079** Above standard	Jun-25: 679; Jul-25: 861; Aug-25: 999; Sep-25: 1079

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	Sept-25	0	**13,617** Above standard	Jun-25: 16172; Jul-25: 15505; Aug-25: 14990; Sep-25: 13617
31.	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	Oct-25	Reduction compared to the same month in the previous year	**26,898** Below standard	Jul-25: 23,473; Aug-25: 24,346; Sep-25: 24,869; Oct-25: 26,898
32.	Number of patients waiting more than 104 weeks for referral to treatment	Sept-25	0	**981** Below standard	Jun-25: 1401; Jul-25: 1498; Aug-25: 1623; Sep-25: 981
33.	Number of patients waiting more than 52 weeks for referral to treatment	Sept-25	Month on month reduction towards the national target of zero by 30 June 2025	**31,707** Above standard	Jun-25: 34374; Jul-25: 33323; Aug-25: 32990; Sep-25: 31707
34.	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	Sep-25	80%	**21%** Below standard	Jun-25: 16%; Jul-25: 19%; Aug-25: 21%; Sep-25: 21%
35.	Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	Sep-25	80%	**73%** Below standard	Jun-25: 68%; Jul-25: 68%; Aug-25: 72%; Sep-25: 73%



Report Title:	Planning Maturity Matrix: CAVUHB's self-assessment				Agenda Item No:	2.3
Meeting:	Finance and Performance Committee	Public	X		Meeting Date:	19th November 2025
		Private				
Status **(please only tick one)**	Assurance		Approval	X	Information/Noting	
Lead Executive Title:	Executive Director of Finance and Planning					
Report Author Title:	Graduate Management Trainee					

Main Report
Background and Current Situation:

Planning is critical in NHS Wales as it provides the structure and foresight needed to deliver safe, sustainable, and high-quality health services. In recognition of this, the Welsh Government developed a Planning Maturity assessment tool to support NHS bodies to self-assess their current capacity and capability to undertake high quality planning and to identify areas for improvement.

NHS Wales organisations that are in escalation for planning, strategy and finance are mandated to undertake this self-assessment annually and submit the outcome to Welsh Government as part of their de-escalation criteria.

This report provides a summary of the UHBs latest self-assessment and serves as a source of assurance to the Board that it remains fully sighted on the organisation's current planning maturity and the actions required to progress through the matrix.

Even if this was not a requirement by Government, undertaking a periodic self-assessment of the organisation's planning maturity remains a valuable exercise. It prompts wider organisation self-reflection, aids in identifying areas for improvement, supports in setting clear targets and goals for planning capability and capacity, with the aim of improving services and outcomes for patients. It also provides an opportunity to raise the planning profile across the organisation and opens the discussion of integrated planning.

The Maturity Matrix tool uses levels 1-5 to assess maturity:

1. Basic Level: Principle accepted and commitment to action
2. Early Progress: Early progress in development
3. Results: Initial achievements
4. Maturity: Results consistently achieved
5. Exemplar: Others learning from our consistent achievements

The Maturity Matrix tool seeks to assess maturity across six specific domains of planning (further subcategories under each domain):

A) Strategy and Plan Development
B) Strategy, Plan Alignment and Development of IMTP
C) Dynamic and Engaged Planning
D) Operational Planning
E) Best Practice Approach to Improvement
F) Realistic and Deliverable

Appendix 1 confirms the maturity matrix in full alongside the narrative against which organisations are required to assess themselves. The boxes highlighted in green donate where the UHB assesses itself to be at sub-domain level. Table 1 below then confirms the UHBs current maturity against each of the six high-level domains.

Table 1:

Domain	Level
Strategy and Plan Development	2
Strategy, Plan Alignment and Development of IMTP	1
Dynamic and Engaged Planning	2
Operational Planning	2
Best Practice Approach to Improvement	2
Realistic and Deliverable	2

This assessment was undertaken through the multi-disciplinary Integrated Planning Group with a summary of the rationale for each level being described below:

Strategy and Plan Development – Level 2
We have self-assessed at this level as we are currently developing a co-designed clinical services plan (CSP) with strong clinical, stakeholder and public engagement. Our vision, purpose and scope is agreed with clear commitment at Board level. National, regional and local priorities are translated into strategic intent. Engagement plans are in place to support the development of the CSP. However, we cannot progress to the next level until our CSP is agreed and implementation is underway, key strategic planning enablers are aligned in planning, strong clinical leadership is reflected in planning, and the organisation has an approved prioritisation framework in place related to the population health needs assessment.

Strategy, Plan Alignment and Development of IMTP - Level 1
This level reflects an inability to provide a financially balanced IMTP, varying alignment is demonstrated between the annual plan and the clinical services strategy (CSS), basic high-level triangulation occurs between services, workforce and finance and lastly, commissioning is reactive with limited strategic alignment. We cannot assess as level 2 due to our unapproved IMTP, lack of alignment between the IMTP and CSS, insufficient triangulation between services, workforce and finance and the lack of an approved and operational commissioning process.

Dynamic and Engaged Planning – Level 2
This level represents broad organisational engagement which is reflected in the CSP and equality impact assessments, the organisation has service risk management approach embedded across all areas and creates robust plans to mitigate risk, and lastly, a strengthened partnership working arrangement is evident. To progress to the next level, we must engage all stakeholders in co-design, including staff, consistently implement our risk management approach across the organisation and align planning across organisations to ensure joint priorities and resource sharing.

Operational Planning – Level 2
Whilst this level demonstrates basic demand and capacity work being undertaken and clinical leads being embedded in the planning cycle and co-producing plans, the organisation only has basic operational plans and planning process in place. We cannot evidence the next level until we undertake demand and capacity at specialty level to support the design of current and future services, clinical leadership must be embedded in operational planning and actively shape services, and operational plans must be regularly reviewed and remedial action undertaken.

Best Practice Approach to Improvement – Level 2
Although we develop proactive engagement strategies and plans, our organisation is only in the beginning stage of exploring value-based healthcare principles whilst planning also remains largely reactive and output-focused. We have a governance structure to provide direction and oversight for the IMTP development, but only basic reporting mechanisms are in place. To progress in this domain, we must embed engagement across all organisational activities, benchmark regularly against other NHS Wales organisations to inform our practice, and a develop a formal governance and accountability framework for IMTP development and monitoring.

Realistic and Deliverable – Level 2
We have a formal risk management process which is applied to IMTP delivery, ownership is clear but integration with delivery assurance is limited. The organisation lacks a financially balanced IMTP and planning remains largely operational and short-term with limited clinical or financial planning alignment. Although we have a structured approach to monitoring the annual plan delivery, it is not yet consistently seen or integrated with performance management reviews. To progress, we must embed risk identification and management within the annual plan/ IMTP and develop a robust, approved annual plan that builds assurance as a key step towards an approvable IMTP.

The UHB is required to justify these levels with robust and well-documented evidence. This is available to the committee upon request but represents a large set of files.

In addition, the UHB is required to have an action plan to improve upon the assessed position with a line of sight to the ultimate 'target' position. Approximately 50 actions have been identified to support with moving up at least one level. These are shown in **Appendix 2**.

These actions are being brought together into a dashboard that the UHB can use to proactively monitor progress with mechanisms also being considered to ensure updates can be provided to Finance and Performance committee, at appropriate intervals, on progress against these actions.

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

This is a newly developed process by Welsh Government which should be welcomed. Its true value lies not in the submission to Welsh Government itself 'per se', but rather the opportunity it provides the organisation to critically evaluate its planning maturity and to develop an action plan that supports continued development and maturity.

Level 5 remains the aspired end position for the UHB as we seek to be 'best in class'. However, it should be noted that achieving this will be a multi-year journey for the organisation and completion of the actions set out in appendix 2 will not automatically take the UHB from its current position to level 5. The UHB should be aspiring to have progressed one level across each domain by the next assessment in twelve months and completion of many of these actions should support achieving this.

While this is a newly introduced process, there remain aspects of the Matrix that are challenging for the UHB to score itself against. For instance, in multiple areas there is a significant jump in expectation between one level and the next. This makes it challenging to accurately self-assess, with the risk of either grossly under scoring or over scoring the organisation. Both options of which do not result in an entirely fair or accurate picture. These areas of concern will be shared with Welsh Government as part of a collaborative effort to strengthen the process in future years.

Appendices (please list all appendices that accompany this report. Do **not** embed)

- Appendix 1: Planning Maturity Matrix
- Appendix 2: Planning Maturity Action plan

Recommendations:

The Committee is requested to:

a) NOTE the current assessment of the UHBs planning maturity
b) NOTE the action plan to support the UHBs future planning maturity.
c) APPROVE submission of this self-assessment to Welsh Government

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. Putting People First	X	2. Providing Outstanding Quality	X
3. Delivering in the Right Places	X	4. Acting for the Future	X

Five Ways 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	x	Not required

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

Risk: No
Safety: No
Financial: No
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:* https://www.gov.wales/socio-economic-duty-guidance
Equality & Health: No

Decarbonisation: No	
Welsh Language: No	
Approval/Scrutiny Route *(please list all other Committees/Groups this report has been to)*	
Name of Committee/Group/Exec	Date:

A) Strategy & Plan Development					Overall level: 2
	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Strategy & Plan	No CSS or delivery plan in place but strategic framework for its development in development.	Draft CSS developed or in development.	Agreed CSS and development of a co-designed clinical services plan underway, with evidence of strong clinical, stakeholder and public engagement throughout. A patient led approach is evident.	Approved CSS and CSP. Implementation underway. Organisation actively identifies risks and opportunities, outcomes are regularly monitored, and planning is informed by data, horizon scanning, and cross-functional collaboration.	The organisation has a fully implemented CSS and CSP that is continuously refined using real-time data and predictive insights. Regular strategic reviews (at least twice annually) are in place that enable flexible adjustments in response to emerging trends and priorities, in-year performance, and long-term opportunities. Strategic planning is agile, outcome-focused, and aligned with system-wide priorities, to maximise opportunities driving measurable improvements in performance and population health.
Vision & Purpose	Organisation is developing its vision and purpose. Clear outcomes are not yet defined.	Vision and purpose, scope and methodology agreed with clear commitment and leadership at a Board and strategy programme level. Clear outcomes are in development.	Organisational vision and purpose with defined outcomes are affirmed in public and internal documents. Organisation demonstrates proactive leadership at Executive and Board level.	Annual Board discussion takes place on organisational vision and purpose ensuring alignment with CSS and enabling plans, intended outcomes and the identification of risks/issues.	Have regular board debate, at least twice annually, on organisational vision and purpose, ensuring alignment with organisational actions, CSS, outcomes and performance and how in-year achievements, issues or opportunities impact on this. Organisation is able to flexibly adjust its CSS to maximise opportunities and remain responsive, outcome-focused, and future-ready.
Alignment of National Policy and All-Level partnership priorities	National policies and national, regional, local and partnership priorities are understood but are not yet translated into organisational strategies and plans.	National policies and national, regional and local priorities have been translated into strategic intent and agreed with stakeholders. WBFG Act and AHW are apparent and embedded in the agreed approach.	Organisational strategies and plans reflect national policies and national, regional and local health and partnership priorities. WBFG Act and AHW principles and integrated throughout.	Strategies and plans are regularly reviewed. They are aligned and responsive to national policy and legislation, and national/regional/local partnership priorities with clear links to the Regional Partnership Board and Public Service Boards.	Strategies and plans are regularly and proactively reviewed and aligned to emerging national policy and legislation, and local, regional and national partnership priorities. RPB's and PSB's are regularly engaged and involved in process. CSS outcomes demonstrate a contribution to the wider local economy, improved health and well-being and operational effectiveness.

Key Enablers	Key enablers—such as quality, safety, workforce, finance, digital technology, and research—are identified but not yet aligned to strategic planning. Their role in enabling delivery is recognised but not actively managed or coordinated.	Key enablers are identified, with plans underway to align them with the organisations overarching CSS. Quality expectations are defined, and initial steps taken to coordinate enabler contributions across programmes.	Key enablers are fully aligned with strategic objectives. Their potential is well understood and actively explored to support delivery. Quality expectations are clearly defined and embedded in planning processes, with enablers contributing to strategic coherence.	Key enablers underpin the development and delivery of the CSS and CSP. Opportunities linked to enablers are translated into actionable deliverables. Quality is integrated throughout the key enabling strategies and plans driving performance and improvement.	Key enablers are embedded across all strategic functions and are delivering measurable improvements and are considered best practice. Their impact is tracked through performance metrics, and they are continuously optimised to support innovation, agility, and system-wide transformation. Quality is not only integrated but drives strategic refinement and outcome achievement.
Engagement in Development	The duties of the Health and Social Care (Quality and Engagement) (Wales) Act (the Act) are identified as integral to the development and implementation of the CSS.	Engagement plans are in place to support the development of CSS.	Engagement plans are agreed and reflect strong clinical leadership. Plans meet the requirements of the Act	Plans are being implemented effectively with robust processes in place to capture diverse voices (internal and external) with strong clinical leadership, and where appropriate and necessary, offers opportunities for stakeholder involvement in shaping the development of CSS.	Organisation operates best practice and continuous engagement with both internal and external stakeholders, exemplifying the values seen in the quality and engagement act, ensuring voices from all communities are heard and reflected in the annual review of the CSS.
Population Health Needs Assessment	Plans are in place to undertake a population health needs assessment.	A basic high level population health needs assessment has taken place and is being used to shape the CSS.	CSS and CSP development is informed by population and health needs assessments and incorporates the wider determinants of health.	There is a single, detailed and regularly updated population health needs assessment in place. Strategies are updated regularly to clearly reflect the outcome of the assessment.	Population health needs assessment is recognised as best practice and is recognised and used by partner organisations (such as PSB and RPB) to form a common and shared understanding. CSS/CSP is regularly tested against current, emerging, and future population health needs.
Priorities & Achievability	The organisation does not have a prioritisation methodology or a recorded list of priorities. Planning is reactive and lacks strategic direction.	The organisation has an approved prioritisation framework related to population health needs assessment and has basic understanding of its priorities but is not yet reflected in plans. health needs.	A prioritisation framework is fully implemented. Priorities are recorded and aligned to population health needs assessments and Cabinet Secretary expectations. Early progress is made to reflect priorities in plans,	The organisation has a published, best-practice prioritisation methodology. It is fully aligned to population health needs and Cabinet Secretary expectations. Prioritised services are proactively reviewed and updated, with robust	Prioritisation is embedded across all planning and decision-making processes. The methodology is sector-leading based on the outcome of the population health needs assessment and Cabinet Secretary's expectations. It is co-produced with stakeholders, and continuously refined through evidence, evaluation, and engagement. Priorities are transparently linked to outcomes, resource

			with initial monitoring arrangements in place.	monitoring and governance of decisions embedded in planning cycles.	allocation, and national policy, with real-time monitoring and adaptive planning in place.
Horizon Scanning	Horizon scanning is infrequent and informal, with no structured process or discussion at Executive or Board level. Strategic planning is reactive, lacking foresight into emerging risks, trends, or opportunities.	Annual horizon scanning is conducted to identify key risks and opportunities. Findings begin to inform strategic thinking, but integration into planning and governance remains limited.	Horizon scanning is carried out regularly and used to test and validate strategic plans against future trends and risks. Insights are reviewed annually and inform planning cycles, with growing Board-level engagement.	Horizon scanning is embedded into strategic planning and governance processes. Findings are discussed at Board level annually, and strategies are actively validated and adjusted based on emerging insights. The organisation uses structured methods to anticipate change and mitigate risk.	Horizon scanning is systematic, forward-looking, and published. It informs biannual Board-level strategic discussions and enables flexible, data-driven adjustments to CSS. Insights are used to anticipate future scenarios, align with system-wide priorities, and ensure the organisation remains agile, resilient, and future-ready.

B) Strategy and Plan Alignment, and Development of IMTP	Overall level: 1				
	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
IMTP Development	Organisation has an annual plan which responds to some but not all elements of planning framework and cannot provide a financially balanced plan over 3 years.	Organisation has an approved IMTP that aligns with the core elements of the planning framework. The plan demonstrates a structured approach to strategic priorities and is informed by baseline data. It includes initial consideration of risks, outcomes, and resource requirements.	IMTP meets almost all policy expectations and is tailored to deliver clear service transformation aligned with an agreed CSP and reflects a shift from operational delivery to strategic impact. Growing maturity in linking planning to measurable impact, return on investment, and strategic priorities. Risks are clearly identified, with evidence of controls and early mitigation strategies.	The IMTP meets all policy expectations and is consistently delivering against the quadruple aim and is embedded across the organisation and transforming services through the CSP. Risks across quality, access, workforce, and finance are actively managed with evidence of controls and mitigation and demonstrates clear alignment between planning, performance, and transformation.	The IMTP exceeds all national policy expectations. It is recognised as a benchmark for excellence, driving system-wide transformation and delivering sustained impact across the quadruple aim. The plan is co-produced, future-focused, and underpinned by robust evidence, innovation, and adaptive governance. It demonstrates clear and advanced triangulation, delivery timelines and milestones, and integrated risks and mitigation.
Alignment between Clinical Services Strategy and Plan and the IMTP or Annual Plan	Some alignment is visible between the annual plan and CSS with the organisation planning on a continuous annual cycle.	Alignment is clear and coherent between the IMTP and CSS with the organisation planning on a continuous annual cycle.	The IMTP is tailored to deliver clear service transformation in line with an agreed Clinical Services Plan. Plans are directly linked to quality, performance and accountability and informed by detailed and future facing modelling.	Coherent aligned plans, including a commissioning plan are performance managed, with staff owning, adapting, acting on and learning from variation.	Planning is owned by all staff and fully integrated and aligned across organisational tiers and system partners. There is a clear golden thread between local, national and regional strategies and partnerships with dynamic alignment to the CSS and Plan, IMTP, commissioning intentions, resulting from horizon scanning results, detailed population health needs assessment and enabling strategies (e.g. workforce, digital, estates).
Triangulation of Services	Basic high-level triangulation is taking place between services, activity, workforce and finance.	Clear triangulation between services, activity workforce and finance.	Detailed triangulation between services, activity workforce and finance at service level.	Clear detailed and robust triangulation and analysis of activity, workforce and finance which considers other holistic requirements such as	Triangulation is system-wide, predictive, and continuously refined through real-time data and advanced analytics. It informs strategic decision-making, resource optimisation, and service redesign across organisational boundaries. The organisation demonstrates a proactive approach

				training and working regionally.	to managing interdependencies, future workforce needs, financial sustainability, and service demand, with clear links to population health, regional collaboration, and innovation.
Commissioning	The Board sets out high level commissioning intentions primarily focused on statutory requirements and broad service categories. Commissioning is reactive, with limited strategic alignment or stakeholder engagement.	The organisation has an approved and operational commissioning process. Intentions begin to reflect service priorities and are informed by basic population health data and stakeholder input.	Commissioning decisions are prioritised based on service need, population health data, and performance metrics. The impact of commissioned and supporting organisations is actively considered.	The organisation has a clear, transparent commissioning plan that includes a transparent prioritisation framework and actions for both commissioning and decommissioning ensuring risk to patients are minimised. Decisions are evidence-based, responsive to changing needs and communicated effectively to stakeholders.	Commissioning is strategically embedded across the organisation and system, with clear alignment to the population health needs assessment, clinical priorities, and service transformation goals. The process is co-produced with stakeholders with a clear and transparent prioritisation framework, underpinned by robust evidence, and includes pro-active decommissioning where appropriate with detailed communication strategies. Commissioning decisions are transparent, equitable, and continuously evaluated for impact on quality, access, and outcomes.

C) Dynamic and Engaged Planning				Overall level: 2	
	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Stakeholder Engagement	Staff and partners are aware of CSS/CSP and there is a public commitment in place to undertake stakeholder engagement.	Organisational engagement is evident in practice and reflected in the CSS/CSP. Broad engagement to inform Equality Impact Assessments and Socio-Economic Duty Assessments.	Stakeholders are engaged in and co-design priority setting using the 'engagement cycle' model and a person-centred approach. Staff engagement at an organisation level is increasing.	Full and proactive continuous engagement including diverse communities which informs, owns and tests all impact assessments. Feedback from engagement activities influences and challenges the plan. Planning is also embedded and co-ordinated throughout the organisation.	Internal continuous engagement sees a fully engaged and informed workforce who are able to co-produce. Feedback and learning from continuous engagement activities including protected characteristic groups and socio-economic disadvantaged groups informs local priority setting and the development of the CSS/CSP.
Service Delivery Risk and Issue Management Approach	Organisation has a service risk management approach in place, but it has not been fully adopted across all areas.	Organisation has service risk management approach embedded across all areas of the organisation and has robust plans in place to address / mitigate risks	A risk management approach is evident and consistent across organisation. The organisation stop fragile services are identified.	The risk management approach enables the early identification of fragile or soon to be fragile services allowing for early intervention to ensure service sustainability. Organisation sees less urgent service changes.	Potential fragile services identified early and robust risk management across organisation pre-emptively responding to emerging service risks and the organisation is able to flexibly adjust plan. The Board are informed and regularly updated on fragile services and organisation rarely sees urgent service changes.
Service Model / Regional Design	Organisation has no route, or route is ineffective to discuss potential opportunities or joint risks. Regional collaboration is minimal, ad hoc, and lacks strategic intent.	Strengthened partnership working arrangements are in place. A methodology for working together is developed, with early efforts to align priorities and build trust.	Opportunities for regional working and shared solutions are identified and developed collaboratively. Planning is increasingly aligned across organisations, with joint priorities and resource sharing.	Agreed proposals for robust regional service models (e.g. consolidation, shared services) are in place and delivery is underway. Governance structures support joint accountability and performance management.	Regional collaboration is fully embedded, strategically led, and continuously evolving. The organisation is a proactive system leader, driving the development, implementation, and optimisation of shared service models and regional solutions. Collaboration is underpinned by co-produced strategies, shared governance, and dynamic intelligence. The organisation anticipates future needs, fosters innovation, and delivers measurable improvements in equity, efficiency, and outcomes across the region.

D) Operational Planning					Overall level: 2
	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Demand & Capacity Modelling	Basic demand and capacity work is undertaken and contains an appropriate level of detail to support service delivery	Demand and capacity planning undertaken at speciality level to support the design of current and future services. Data is more structured and used to inform service-level decisions	Robust and profiled projections of demand and capacity are used to inform the development of individual service plans, the Clinical Services Plan, and the IMTP. Planning is increasingly data-driven and cross-functional.	The organisation uses detailed and advanced modelling capability to support strategic planning. Demand and capacity modelling is embedded in the IMTP and informs transformation, workforce, and financial planning. Predictive analytics and AI tools support long-term planning.	Demand and capacity modelling including modelling projections is at the core of planning processes across the organisation. Predictive analytics and AI tools support long-term planning. Modelling triangulates resources, staff, finance and activity. It is able to undertake modelling at all levels of prevention and illustrates scenarios for improvement for the IMTP.
Clinical Leadership & Input	Clinical leads are identified and their roles are defined. Engagement is limited to basic consultation or information sharing	Clinical leads begin to inform service planning and contribute to performance improvement discussions. Their input is considered but not yet central.	Clinical leads are embedded early in the planning cycle to ensure that service design is clinically credible and patient-centred. Clinical leads co-produce plans and provide leadership in development processes. Their involvement is structured and increasingly strategic.	Clinical leadership is embedded in operational planning. Clinical teams actively shape service direction in alignment contributing to future direction services in line with clinical services plan.	Clinical leadership sits at the heart of planning and performance with a strong focus on quality and improvement. Clinical leaders co-produce plans and drive the future direction of plans through developing a culture of quality, innovation, and continuous improvement, fostering deep engagement and ownership across clinical teams.
Planning Process	Organisation has basic operational plans and planning process in place.	Operational plans are regularly reviewed and remedial action undertaken.	Operational plans have robust triangulation and modelling of plans based on a clear and consistent approach to demand and capacity modelling across the organisation	Coherent aligned and triangulated plans with clear links to CSS and CSP, including, with staff owning, adapting, acting on and learning from variation and inequity.	Operational plans are fully aligned and integrated into the development of IMTP and CSP. Staff own the process and act on opportunities and learning to improve holistic service provision and patient experience.

E) Best Practice Approach to Improvement					Overall level: 2
	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Engagement	Engagement is minimal and reactive. Feedback is collected from patients and staff, but there is no structured approach to measuring the effectiveness of engagement activities or approach. Insights are rarely used to inform decision-making.	The organisation has a visible commitment to best practice, supported by training and an improvement strategy. Engagement with national programmes is active, and structured methods for collecting feedback and measuring impact are in place, though not yet fully embedded.	Organisation is developing an engagement strategy/plan and is proactive in identifying and learning from best practice in engagement to ensure voices are captured from all stakeholders especially clinical, minority and diverse voices.	Engagement is embedded across all organisational activities—planned and unplanned. The engagement strategy ensures robust inclusion of diverse and clinical voices, supported by strong data collection and analysis. Feedback directly informs action, driving continuous improvement.	Stakeholder engagement is transformational—co-designed and co-led by patients, staff, and communities. Real-time feedback tools enable adaptive responses, while inclusive practices ensure diverse voices shape decisions. The organisation is nationally recognised for its leadership in engagement, with a clear link between stakeholder input and measurable improvements
Benchmarking	Organisation is beginning to explore value-based healthcare principles, but planning remains reactive and output-focused. Benchmarking is ad hoc, with limited structure or consistency. There is minimal understanding of how comparative data can drive improvement, and benchmarking is not yet linked to strategic goals.	Value-based planning is gaining traction, and regular benchmarking is conducted with other NHS organisations. The organisation begins to use structured benchmarking methods to identify best practice, though application is inconsistent. Staff awareness is growing, and benchmarking is starting to inform service reviews and improvement discussions.	Benchmarking processes are formalised, consistently applied, and span across Wales and the UK. The organisation uses comparative data to identify performance gaps and inform strategic planning. Benchmarking is aligned with value-based healthcare principles, and results are used to prioritise improvement initiatives. Staff are engaged in interpreting data and applying insights to their areas.	Benchmarking is fully integrated into planning and performance cycles. Staff across the organisation actively lead benchmarking and improvement initiatives, using data to drive decisions and measure impact. There is a strong culture of ownership and continuous learning. Benchmarking includes qualitative and quantitative measures, peer comparisons, and outcome-focused metrics aligned with patient value. Insights are shared across teams and used to scale best practice.	Demonstrates full integration of benchmarking and value-based planning across strategic, operational, and clinical areas. Advanced analytics, including predictive and real-time data, drive proactive improvements and innovation. Recognised as a leader in the NHS, the organisation shapes best practice while fostering a culture where staff lead continuous improvement and scalable innovation.
Governance	Governance arrangements are informal, fragmented, or unclear. Oversight of IMTP development is minimal, with limited	A governance structure has been established to provide direction and oversight for IMTP	A formal governance and accountability framework is in place for IMTP development and	Governance is embedded across the organisation, with a mature CSS and oversight mechanisms that are	Governance is fully integrated, agile, and strategically aligned across all levels. Oversight of the IMTP, CSS and CSP is co-produced with clinical leaders and stakeholders, supported by

	accountability, transparency, or alignment to strategic priorities. There is no structured process for risk management, stakeholder involvement, or performance monitoring.	development. Roles and responsibilities are defined, and basic reporting mechanisms are in place. There is growing awareness of the need for structured governance, but integration with programme-level planning and delivery is still emerging.	monitoring at programme level. IMTP and CSS/CSP governance is aligned with strategic objectives, includes defined escalation routes, and supports performance tracking. IMTP Governance is periodically tested for improvements.	reviewed annually for relevance and effectiveness. IMTP and CSS/CSP governance structures support cross-functional collaboration, robust data use, and continuous improvement. Governance is constantly and pro-actively tested for improvements.	real-time data, predictive analytics, and dynamic risk intelligence. IMTP/CSS/CSP governance structures are benchmarked against national best practice, continuously refined, and used to drive innovation, accountability, and system-wide impact. Decision-making is transparent, inclusive, and outcome-focused.

F) Realistic & Deliverable					Overall level: 2
	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Risk Identification & Management	Risk identification and management are inconsistent and reactive. Risks to IMTP delivery are not systematically captured or monitored. There is limited ownership or visibility of delivery risks.	A formal risk management process exists and is applied to IMTP delivery at a high level. Risks are identified at the planning stage and tracked through basic registers and reviewed periodically. Ownership is clearer, but integration with delivery assurance is limited. Escalation processes in place but not always followed.	Risk identification and management are embedded in IMTP development and delivery processes. Risks are identified early and linked to specific objectives, milestones, and outcomes. Controls are monitored, and mitigation actions are tracked. Risk registers are dynamic and inform delivery with clear ownership.	Risk management is proactive, strategic, and forward-looking with an agreed and clear risk appetite. Risks are anticipated and identified through horizon scanning, sensitivity analysis and scenario planning. The organisation adapts delivery plans in response to emerging risks with regular reviews. Lessons learnt informs future IMTP cycles.	Risk management is fully embedded across the organisation and system partners and is triangulated across workforce, finance, digital and clinical lenses. It is predictive, real-time, and continuously informs IMTP delivery through live dashboards and predictive analysis. The organisation leads in using risk intelligence to drive improvement, resilience, and transformation. The organisation operates continuous learning and is recognised for excellence in risk-informed delivery assurance.
Development of IMTP and track record	The organisation has a track record of submitting annual plans that do not meet the requirements of the planning framework, Cabinet Secretary expectations or provide a financially balanced plan over 3 years. Planning is largely operational and short-term, with limited strategic integration and has limited clinical or financial planning alignment and limited stakeholder engagement.	The organisation consistently develops robust annual plans that build assurance as a key step toward an approvable IMTP. Plans begin to reflect medium term priorities, include a finance and delivery framework, and show early signs of strategic alignment including financial forecasts and delivery milestones.	The organisation has developed an approvable, outcomes-focused IMTP that reflects strategic priorities, enabling plans and clinical service plans. A robust 3-year sustainable financial plan is included, with clear links to service transformation (with milestones and timelines) with clearly articulated risks and mitigations.	The organisation has a history of submitting high quality IMTP's that are strategically integrated and includes a comprehensive delivery and assurance framework. It demonstrates alignment across all enabling strategies and is informed by detailed modelling, population health intelligence, and with significant stakeholder input.	The organisation is recognised for excellence in IMTP delivery and assurance and has a long history of developing and submitting high quality IMTP's which surpass policy expectations and is recognised as a system-leading exemplar. It is co-produced and informed by detailed analysis and predictive tools to drive transformation across the health system, delivers the quadruple aim.
Monitoring and Delivery	Monitoring of annual plan or IMTP delivery is ad hoc and reactive and focused on immediate operational issues. There is limited visibility of progress, and	The organisation has a structured approach to monitoring annual plan or IMTP delivery with ownership of delivery emerging across services.	Monitoring of IMTP delivery is consistently seen as business as usual and integrated with performance	IMTP delivery is monitored through a robust, outcome-focused framework which includes impact evaluation. The organisation adapts delivery plans based on	IMTP monitoring and delivery are embedded in real-time, system-wide performance and governance structures. The organisation demonstrates strategic leadership in delivery assurance, advanced triangulation, using predictive analytics, scenario planning, and co-

	reporting is inconsistent. Accountability is unclear and delivery risks are not systematically managed.	Key milestones and actions are tracked, and reporting mechanisms are in place through basic dashboards and reported to the Board regularly. Accountability is improving, but integration with performance and risk management is limited.	management reviews and risk assurance processes. Progress is tracked against outcomes, and corrective actions are taken. Delivery is supported by enabling functions and aligned with strategic priorities. Delivery is starting to inform future planning.	performance insights, emerging risks, and system pressures. Staff are engaged in owning and delivering IMTP priorities.	produced improvement plans. Delivery is continuously optimised to achieve the quadruple aim. Continuous improvement cycles are embedded, with clear evidence of impact and the

CAVUHB Planning Maturity Action Plan

Domain	Subcategory	Current Level	Actions to enable progression to at least next level	Target completion
A) Strategy and Plan Development	Strategy and Plan	3	1. Executive steering group (ESG) whole day session to set the strategic priorities that will guide the 26/27 planning cycle 2. Board approved CSP 3. Implementation of our strategic portfolios to drive our IMTP priorities for 25/27 to enhance and coordinate alignment between strategic, tactical and operational planning	Q3 Q4 Q3
	Vision and Purpose	2	1. Executive SROs to hold first Portfolio Boards and agree scope and terms of reference (ToR) 2. Board Development Session to discuss strategic portfolios progress and agree a process for regular board reporting 3. Regular Board debate, at least on an annual basis, whereby organisational purpose, vision and strategy is discussed and the impact of in-year achievements or issues 4. Lead measures are in place and LAG measures are in development as part of the portfolio outcomes work to enable the organisation to map our delivery to strategy	Q2 Q3 Q3 Q3
	Alignment of National Policy and All-Level partnership priorities	2	1. National and regional priorities are reflected within our CSP and our IMTP - SEW and RPB	Q4
	Key enablers	1	1. Set out implications for key enablers within the CSP	Q4
	Engagement in Development	2	1. Execute 20-week engagement plan for the CSP 2. Internal workshops to be held to develop CSP	Q3 Q3
	Population Health Needs Assessment	1	1. To be an active partner in the current PNA assessment	Q4
	Priorities and Achievability	1	1. Be an active partner in the current PNA exercise 2. Deliver an acceptable Annual Plan 3. Director of Commissioning taking up post	Q4 Q4 Q1 26/27
	Horizon Scanning	2	1. Ensure that assessment of horizon scanning is embedded in executive away days twice yearly 2. Horizon scanning assessment against developing strategic plans at portfolio board meetings	Q4 Q4

	IMTP development	1	1. We will undertake a mapping exercise between the planning framework and our annual plan to be assured on how we have responded to the framework	Q4
B) Strategy, Plan Alignment and Development of IMTP	Alignment between Clinical Services Strategy and Plan and the IMTP or Annual Plan	1	1. Develop appropriate delivery and planning mechanisms ensuring alignment between the CSS and annual plan delivery 26/27 and beyond	Q4
	Triangulation of Services	1	1. Produce a minimum data set (MDS) at clinical board (CB) level which combines workforce, finance and operations data from the bottom up, rather than the current top down approach 2. Further improve consistency between workforce and finance data systems 3. Ensure approved priorities are underpinned by triangulated detailed plans 4. Hold internal planning events in Q3 with Clinical Boards to triangulate workforce, finance, and operations data, informing the development of the 2026/27 Annual Plan	Ongoing
	Commissioning	1	1. Appoint a Director of Commissioning 2. Subject to appointment, seek to develop a strategic approach for the UHB to discipline commissioning and planning	Q3 Delivery from Q1 26/27
C) Dynamic and Engaged Planning	Stakeholder engagement	2	1. Create an integrated impact assessment (IIA) with a lead expert and governance process in place to sign off each impact assessment 2. Execute 20-week engagement plan for the CSP	Q4 Q3
	Service Delivery Risk and Issue management approach	2	1. Continue the expansion of AMaT so that all organisation risk registers are consistent, visible and able to comprehensively be reviewed 2. Yearly update of fragile services 3. Continued engagement with JCC on fragile specialist services 4. Inclusion of fragile services review as part of Clinical Board Executive Reviews	Q4
	Service Model/ redesign	2	1. Increase pace with shared estate across RPB partners 2. Embed the regional JC and establish its remit	Q3 26/27 Q3 26/27
D) Operational Planning	Demand and Capacity Modelling	1	1. Expand the demand and capacity to include urgent and emergency care 2. Develop, resource and implement organisational approach to modelling and forecasting and alignment with medium and long term resource planning (workforce and finance) 3. Improve the minimum data set at directorate level	26/27 Q3 Q3

	Clinical Leadership and Input	3	1. Ensure that clinical leadership is reflected in the CSP through including outputs from SLT workshops	Q4
	Planning Process	1	1. Undertake resource mapping exercise against the Annual Plan - cross reference with Operational Planning to clarify roles and responsibilities 2. Undertake a review of our operating model for planning in the organisation- including assessment of capacity and capability (once director in post)	Q2 (26/27) Q2 (26/27)
	Engagement	3	1. Further develop Planners Collaborative to share best practice, develop culture for planning and to provide support to all levels of the organisation 2. Build on the relationships created through the engagement process of the CSP to further support future and continuous engagement 3. Monthly meetings with the Shaping Change lead for Insight to further inform the engagement data 4. Development of a central point to store all engagement activity and data - organisational wide	Q3 Q3 Q3 Q4
E) Best Practice Approach to Improvement	Benchmarking	1	1. Approval of Value 25/26 Plan. Toolkit in development on the Value SharePoint, available to support in working through a project plan, delivering and measuring Value 2. Develop a Value Impact Tracker which aims to evaluate the impact of projects across each Value-Based principle, aggregating data in terms of cost impact, activity impact, deprivation impact, PROM/PREM etc. The ambition is to adopt this widely across corporate processes once pilot has been completed 3. Support Clinical Boards to implement and improve the required elements with the 5 High Value, High Impact Pathways- Diabetes, Bone Health, Heart Failure, Arthroplasty (Hip & Knee). This is a ministerial enabling action and a priority in the CAVUHB Value Programme Annual Plan 4. Continue to embed Value Based Principles into the core way the organisation operates. Embedding Value Based Principles from Ward to Board – through improvement, evaluation and decision making. Continually enhancing the way think and operate across the UHB by providing tools and resources, training and development, utilising our Clinical Leadership roles as well as our matrix team skills within the programme	Q2 and ongoing Q3 Q3 and ongoing Q2 and ongoing

	Governance	2	1. Review planning process to fit with the objective of producing an 'acceptable' annual plan through - Clear planning assumptions and parameters appropriate to an annual plan - Delivery focused: ensuring clear actions, milestones, measures and ownership	Q3
F) Realistic and Deliverable	Risk identification and management	2	1. Further mature the approach to deliver the annual plan/ IMTP by embedding a dynamic reporting process into existing organisational governance arrangements	Q1 26/27
	Development of IMTP and track record	1	1. Development of a credible 26/27 annual plan	Q4
	Monitoring and delivery	2	1. Start shifting to outcomes focus strategic framework 2. Develop mechanisms to ensure IMTP delivery is tracked at Senior leadership Board (SLT) and Clinical Board level	Q3 Q1 26/27

Report Title:	Accountable Officer Letter: 2025-26 Strategic Cash Request Submission			Agenda Item no.		2.4	
Meeting:	Finance and Performance Committee	Public	x	Meeting Date:		19th November 2025	
		Private					
Status:	Assurance		Approval	x	Information		
Lead Executive:	Executive Director of Finance						
Report Author:	Deputy Director of Finance						

Background and current situation:

SITUATION

2025-26 Technical Update 3 issued by the Finance Directorate, Health Social Care and Early Years Group, Welsh Government on the 7th November 2025 confirmed that Health Boards are required to submit an Accountable Officer letter (once requirements are established) in support of a request for Strategic Cash Support in 2025/26. Application requests must be submitted by Monday 8th December 2025.

The following application requirements are in place for Strategic Cash Support to ensure appropriate oversight from LHB Boards:

- All applications for Strategic Cash Support are required to be made to Jacqueline Totterdell Chief Executive NHS Wales, Jacqueline.Totterdell@gov.wales and copied to Hywel.Jones038@gov.wales, Matthew.Denham-Jones@gov.wales and Jacqueline.Salmon@gov.wales

- All applications are to be approved by the Board prior to submission, including consideration of the cumulative cash support position of the LHB and the actions management are taking to mitigate the cash support requirement;

- Actions management are taking to mitigate the cash support requirements

- All applications to be made by the Accountable Officer of the LHB.

The UHB has highlighted its 2025/26 year end cash deficit arising from its forecast deficit within the monthly monitoring return which is submitted to Welsh Government. In addition, the Finance Committee has been advised that in due course, the UHB expects to seek Finance Committee and Board approval to request £56.233m strategic cash support from Welsh Government to cover the cash shortfall arising from the forecast deficit.

At month 7, the UHB is reporting an overspend of £35.619m and is working to recover the month 7 operational and savings overspend to deliver the £56.233m planned deficit. The UHB also continues to strengthen its processes to recover all income due on a timely basis.

In addition to the forecast deficit, the UHB has noted material risks to its financial position in respect of the band 2/3 pay arrears risk £8.185m and the potential additional Welsh Risk Pool contribution (£7.378m + £1.906m). **If the month 7 financial forecast is not delivered, the UHB may need to seek additional approval from Board to submit a further application to Welsh Government for supplementary strategic cash support**.

The UHB received strategic cash support of £26.900m in 2022/23, £16.460m in 2023/24 and £9.100m in 2024/25. Therefore, the cumulative cash support position of the LHB will stand at £108.693m if a 2025/26 request for £56.233m is approved.

Table 1 - Cumulative Strategic Cash Support

Year	Support	Amount £m
2022/23	Strategic Assistance	26.900
2023/24	Strategic Assistance	16.460
2024/25	Strategic Assistance - approved	9.100
2024/25 cumulative	**Cumulative Strategic Cash support at the end of 2024/25**	**52.460**
2025/26	Strategic Assistance - requested	56.233
2025/26 cumulative	**Cumulative Strategic Cash support at the end of 2025/26**	**108.693**

In addition to the strategic cash request, the UHB estimates that it requires £17m of working cash support to cover in year movement in its revenue and capital working balances since April 2025. The UHB has reported this requirement to Welsh Government through the Monthly Monitoring Returns (MMR) and will continue to review the requirement for working balances cash as the year progresses.

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

The UHB request for Strategic Cash Support in 2025/26 is consistent with the forecast deficit reported through the UHBs Finance Committee.

Recommendation:

The Board/Committee are requested to:

a) **NOTE** the UHBs current assessment of £17.000m working cash balance support.

b) **Recommend** that the UHB's Board approves the UHB's application to Welsh Government for £56.233m Strategic Cash Support in support of its 2025/26 forecast deficit.

Link to Strategic Objectives of Shaping our Future Wellbeing:

https://shapingourfuturewellbeing.com/

Putting People First		Providing Outstanding Quality	
1. **Click the objective above to view more detail.**		2. **Click the objective above to view more detail.**	
Delivering in the Right Places		Acting for the Future	
3. **Click the objective above to view more detail.**		4. **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		

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):*	
Finance and Performance Committee	Date: 19th November 2025

Report Title:	Board Assurance Framework		Agenda Item no.	2.5	
Meeting:	Finance & Performance Committee	Public Meeting	x	Meeting Date:	19th November 2025
		Private Meeting			
Status:	Assurance		Approval		Information x
Lead Executive:	Catherine Phillips, Executive Director of Finance				
Report Author:	Andrew Gough, Deputy Director of Finance				

Background and current situation:

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

The Board Assurance Framework (BAF) highlights the strategic risks, impacts and controls in place across the decarbonisation and climate agenda

Appendices *(Please list any appendices that will accompany this report, do **not** embed within documents)*

1) Board Assurance Framework

Recommendation:

The Committee is requested to:

a) Note the position on both the decarbonisation and climate agenda

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.**	

Five Ways of Working (Sustainable Development Principles) considered:

Prevention		Long term		Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?

Yes		No		

Impact Assessment:
Risk: na
Safety: na
Financial: na
Workforce: na
Legal: na
Reputational: na
Socio Economic: na - ***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: na
Decarbonisation: na
Welsh Language: na

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

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Shaping Our Future
Wellbeing

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Cardiff and Vale University Health Board

Board Assurance Framework

Updated 27 Nov 25

Introduction

The Board Assurance Framework (BAF) is the tool and document that seeks to articulate what strategic risks an organisation has identified that will, if not addressed, prevent it from delivering its strategy.

There is no definitive format, and it is intended that the below pages present in as clear a manner as possible the alignment between CAVUHB's 4 strategic objectives, the strategic portfolios that are led by the Executives in order to turn the strategy into delivery over the course of the strategy, the strategic risks that have been defined to best articulate the major themes that could prevent the delivery of the strategy, and the Board's Committees that are charged with seeking assurance on and scrutinising the delivery of each strategic objective.

While each strategic risk aligns to a Committee, the risks themselves are applicable to all 4 strategic objectives and have a whole organisation perspective and impact. Each has a risk appetite as determined by the Board.

Each risk seeks to identify the potential cause and effect of a manifestation of the risk becoming an issue. This 'uncontrolled' assessment makes use of a simple 5 x 5 scoring guide for likelihood against impact:

Likelihood / Impact	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Severe (5)
Almost Certain (5)	5	10	15	20	25
Likely (4)	4	8	12	16	20
Moderate (3)	3	6	9	12	15
Unlikely (2)	2	4	6	8	10
Rare (1)	1	2	3	4	5

Each risk is then assessed for the different controls and assurance measures or mechanisms that are in place, as well as identifying where there may be gaps in these facets. Once these have been applied a new assessment, using the above scoring system again, is then made.

However, the BAF is not a definitive mechanism or science. It is a vehicle for the organisation to articulate and expose some of the strategic level impacts on delivering the strategy, and for the Board and Committees to pull through and scrutinise those elements that are appropriate.

Finally, the BAF seeks to articulate the activity taking place relevant to each risk for assurance.

This document looks to capture and present this information so that the Board and members of the public can see all of the above information, the trends in scoring, the actions being undertaken and every change made to the document between one Board meeting and the next through the use of track changes.

Shaping Our Future Wellbeing

Strategic Framework

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Cardiff and Vale University Health Board

Strategic Framework						
Strategy	**Putting People First**	**Providing Outstanding Quality**			**Delivering in the Right Places**	**Acting for the Future**
Strategic Portfolio	Shaping Our Future People & Culture	Shaping Our Future Population Health & Place Based Partnerships	Shaping Our Future Quality, Value & Sustainability	Shaping Our Future Clinical Services	Shaping Our Future Infrastructure	Shaping Our Future Generations
Strategic Risk Theme	People	Quality			Digital	Sustainability
		Health Equity			Infrastructure	
Committees	People and Culture Committee	Quality Committee			Digital and Infrastructure Committee	Finance and Performance Committee
		Mental Health Committee				
	Audit & Assurance					

Shaping Our Future Wellbeing

Strategic Objectives

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Strategic Objectives			
Putting People First	**Providing Outstanding Quality**	**Delivering in the Right Places**	**Acting for the Future**
We will be a great place to train, work and live, where we listen to and empower people to live healthy lives. By 2035, colleagues would recommend us a great place to work, our workforce will reflect the diversity of our communities and more people will be living healthier lives.	We will provide outstanding services which are equitable, timely and safe, where people are treated with kindness and are supported to achieve the outcomes that matter to them. We will have reduced inequities in prevention, improved access to clinical services and clinical outcomes.	By 2035 we will be using real time integrated data to inform joint decision making and multi-disciplinary team working, giving people access to and ownership of their data to enable them to manage their health and wellbeing. We will be well on our journey to provide care in the right place, in facilities that are fit for purpose, flexible and promote recovery.	We will work to ensure that what we do today does not compromise the wellbeing of our future generations. We will protect the environment and develop and use new technologies, treatments and techniques to provide the best possible health outcomes and sustainable health care into the future. By 2030 we will have reduced the Health Board's carbon footprint by 34% and will have increased our research and clinical innovation activities.
People will feel valued, developed, supported and engaged. We will have an inclusive culture where the diversity of the Health Board's people will be representative of the Health Board's local populations. Through our integrated population health improvement programme, we will enable and empower people to live healthy lives and reduce their risk of ill health.	Focus on minimising inequity in healthy behaviours, preventative services, access to clinical services, and health outcomes, to reduce current unfair, unjust differences experienced by people in the community Deliver outstanding quality of care every time - from the most complex care for the most critically ill to routine care that prevents and protects against ill health and disease – addressing physical and mental health needs. Achieve the best outcomes for patients in line with what matters most to them, their families and carers. Develop the Health Board's approach to continuous quality to improvement and make the best use of the Health Board's resources.	To achieve digital maturity enabling the Health Board to connect and communicate, supporting shared decision making in the planning and delivery of health care services. Refresh and deliver the Health Board's programme for creating integrated health and care facilities in our local communities where people can access the information and support they need under one roof. With Cardiff University and NHS partners, develop the Health Board's plans for ensuring hospitals providing acute care are fit for the future. Develop more shared infrastructure with public and private sector partners to get best value for the Health Board's investment.	Develop and expand the Health Board's research, teaching and innovation portfolios in collaboration with Cardiff University and other partners. Contribute to the development of and adopt cutting-edge and novel treatment, techniques and technologies where they deliver improved patient outcomes and improved value. Maximise the Health Board's contribution to the foundational economy Deliver the Health Board's carbon emissions targets and fully support active and sustainable travel for staff and visitors to patients. Promote, reward and embed successful waste reduction as part of our quality programme of continuous improvement.

Shaping Our Future Wellbeing

Strategic Risks – Quality

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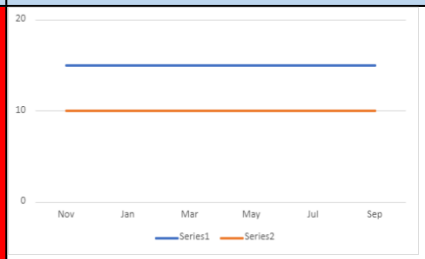
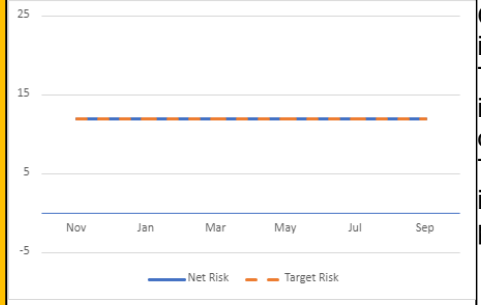
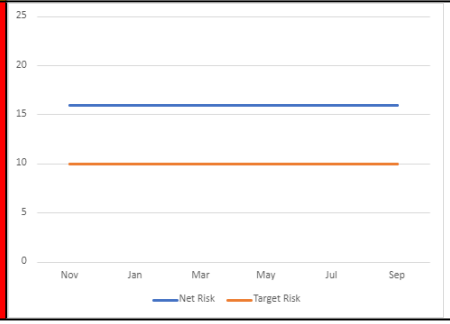
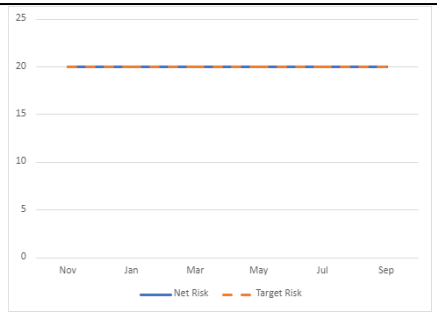
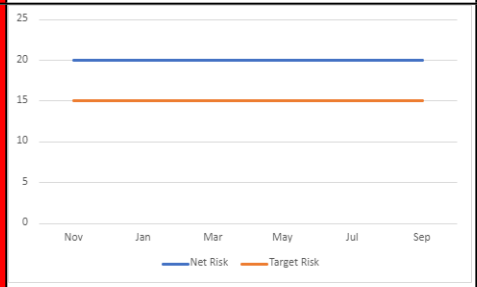
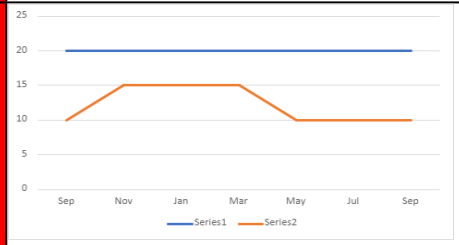
Cardiff and Vale University Health Board

What will prevent Cardiff and Vale University Health Board from delivering its strategy?
If any of the below risk themes cannot be controlled, then the strategic objectives are unlikely to be met.

Strategic Risk	Risk Appetite / Target Risk	Gross Risk *(no controls)*	Net Risk *(after controls)*	Trend	Context	Executive Lead(s)
Quality	Cautious 10	25	15		Our ultimate priority - to continuously, reliably, and sustainably meeting the needs of the population that we serve. Our organisation will focus on delivering assurance on the six domains of quality with the ultimate aim of providing outstanding care to our patients. We will strive to deliver Safe; Timely; Effective; Efficient; Equitable and Person-Centred Care.	Exec Dir Nursing Exec Medical Dir Exec Dir AHPs and Health Science Chief Operating Officer
Health Equity	Open 12	16	12		One of our two statutory responsibilities as a Health Board is to improve the health and well-being of our local population. The overall aim of our strategy is: 'Working together, we will help improve lives so that by 2035 people are healthier and unfair differences in health outcomes are reduced.' The goal is to improve health outcomes by reducing inequity in indicators of healthy behaviours and increasing the use of preventative services and access to clinical services.	Exec Dir Public Health
People	Open 10	20	16		The most important asset of any organisation. Through the delivery of the People and Culture Plan, our strategy will be delivered with a key focus on these core People risks: Attract, Recruit, Retain | Culture | Wellbeing	Exec Dir People

Strategic Risks – Quality

Digital	Cautious 20	25	20		Data is integral to our strategy. It empowers informed decision making about what we need to do, why, when and how we perform. Delivering our digital and data transformation road map will introduce actionable insights and capabilities that enable clinicians and patients in any setting delivery of safe, high-quality care, improving productivity, efficiency and communication through person centric digital solutions. The security, management and accessibility of data is essential.	Dir Digital
Infrastructure	Open 15	25	20		The Health Board has the largest hospital in Wales, a footprint across dozens of locations and integrated service locations with key partners. We must shape our future infrastructure to ensure facilities are fit for the delivery of modern healthcare, intelligent integration takes place with partners and the service is delivered in the right locations for our population.	Exec Dir Finance
Sustainability	Cautious 10	25	20		Sustainable, efficient services are a legal requirement, improve quality and ensure a sustainability of service for now and future generations. By articulating the strategy through the integrated mid-term plan and the proper alignment of resources and consideration of the environment the Health Board will meet its statutory duty and ensure value in delivery.	Exec Dir Finance

Risk Appetite			
Avoid	Avoidance of risk and uncertainty is a key organisation objective	Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (VFM)
Minimal	Preference for ultra-safe delivery options which have a low degree of inherent risk and only for limited reward potential	Seek	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)
Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential reward	Mature	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

Strategic Risks – Quality

Strategic Risk	Strategic Portfolio	Exec Leads	Committee	Date Added
Quality	Shaping our Quality, Value & Sustainability	Exec Dir Nursing | Exec Medical Dir | Chief Operating Officer Exec Dir Therapies and Health Science	Quality	30 Sep 24

Risk

Delivering outstanding quality and eliminating avoidable harm is the ultimate priority of the Health Board, however, constraints associated with capacity,
Capacity, governance and leadership to deliver measurable success across each of the six domains of quality impacts on the ability to deliver quality all the time and for the entire population

Cause	Impact
Safe – avoiding harm to service users and staff Risk to delivering safe care is increased due to demand pressures, workforce shortages, aging physical estate, lack of digital technology and variation across the organisation.	**Safe** The UHB continues to see a number of same cause patient safety incidents, complaints, redress cases and claims where the harm to patients is potentially avoidable. These include health care associated infections, failure to ensure continuity in clinical pathways, failure to recognise the deteriorating patient, failure to escalate, issues with communication and Never Events. The health, safety and welfare of our staff is not universally maintained.
Timely – providing care within an appropriate timescale to avoid harmful delays Ability to deliver timely care is significantly impacted by the backlog of referrals following the covid-19 pandemic and the mismatch between demand and recurrent capacity within many clinical services	**Timely** Long waiting times for planned care and diagnostics means care is delivered at inappropriate timescales with a potential consequence of progression of disease, worsening wellbeing and associated psychosocial impact on patients and families. Care is ultimately costlier to provide.
Effective - providing services based on scientific evidence and refrain from providing treatments and services that do not benefit patients Ability to deliver effective care is impacted by workforce pressures, outdated systems and process, particularly related to digital technology, clinical coding and aging physical environments. The challenge in accessing real time data to track care against a robust evidence base means that the organisation is dependent on retrospective data to inform its response to quality risk	**Effective** Benchmarked data associated with national clinical audits demonstrates that we don't universally benchmark in the top 30% of organisations nationally for performance and outcomes. The pressure on estates, workforce capacity and wellbeing will impact on our ability to provide care in line with evidence base.
Efficient - avoiding waste that does not add value to the patient or the desired outcome Risk to delivering efficient care is caused by outdated systems and process, particularly related to digital technology and aging physical environments and workforce efficiency	**Efficient** The Health Board is not meeting some of its productivity and efficiency ambitions, including in relation to outpatients and length of stay. Care may be being delivered which does not provide value to the patient, wider population and health economy. Care can be duplicative and wasteful. Care is often delivered with a disproportionate focus on intervention vs prevention. Constraints around workforce availability results in a reliance on non UHB staff to provide core.
Person Centred - providing care that is respectful and responsive to patient's values and needs In order to reduce the risk of not delivering person centred care the organisation must seek understanding of our population, empower patients, seek options to receive feedback and develop a responsive culture.	**Person Centred** The Health Board is striving to deliver care that meets the patients right to empathy, compassion, privacy, dignity and respect. In some areas patient experience is below our ambition, for example in the Emergency Department which is below the 85% target in all but one measure. The Health Board is seeking to ensure patients and families views are sought and play a role in improving services.
Equitable - Our health care system provides everyone with an equal opportunity to attain their full potential for a healthy life We embed equality and human rights in our health care system.	

Strategic Risks – Quality

We design services that meet the needs of our local population.		**Equitable –** Our health outcomes between different population groups (e.g. most deprived and least deprived and different ethnic groups indicate that we have more work to do on this aspect of quality. We have developed an 'Equity, Equality and Patient Safety Framework for the Health Board' this describes a framework for change, provides examples of best practice from across the world, and finally outlines the key actions each Clinical Board has committed to. For example, our data collection of protected characteristics is poor, and each Clinical Board will need to make improvements in this area. Using a co-production approach supports equity.	
Uncontrolled Risk			
Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 10

Controls	Assurances
Safe – Corporate Quality and Safety team have oversight of all UHB patient safety incidence, the Duty of Candour supports systematic scrutiny of all incidents reported as having caused moderate harm and above. Quality Committee and the groups that report into the committee provide oversight of emerging trends. The clinical safety group brings together the clinical boards and clinical advisory groups to support the development of strategy and policy to deliver quality aligned to current risk. The Shaping our Future Quality Excellence Programme is designed to address emerging patient safety themes. The Theatres Together programme is overseeing improving work in theatres that has emerged from the recent theatres review. **Timely**- Planned Care programme and Operational Performance meetings delivering on plans to reduce waiting times. Patients prioritised in line with Health Board criteria – Urgent and Emergency Care; Cancer and Time-Critical; planned (in referral order). Recovery plans are in place for diagnostic long waits such as endoscopy and non-obstetric ultrasound. **Effective –** The Clinical Effectiveness Committee provides oversight of national clinical audit outcomes and improvements and implementation of NICE and HW guidance. Clinical Boards are bringing an overview of their local arrangements to providing continuous focus of national audit data and use it to transform clinical pathways as has been done in stroke and hip fracture. Work is planned as part of the Sharping our Future Quality Excellence – Quality Management System Project to standardise the collection of national audit data and to embed it into quality governance structures. **Efficient –** operational programmes in planned care and urgent and emergency care focused on delivering best practice. Benchmarking and use of GIRFT central to programme. Productivity and Efficiency ambitions in place and monitored. **Person Centred –** Value Based Healthcare programme supporting projects and programmes focused on delivering value to patients. The UHB is rolling out a new PROM platform "Promptly" throughout the organisation to provide reliable opportunities to collect this information.	• Clinical Board Performance Meetings • Integrated Performance Report • QSE • Clinical Effectiveness Committee • Clinical Safety Group • Risk registers • Executive Reviews • People and communities experience framework • CIVICA • Benchmarking Information (Clinical) • Get It Right First Time • Peer Reviews • HIW and external assurance • PSOW REPORTS • WRP assessments • Accessibility standards • Equity, Equality, Experience and Patient Safety Framework and Action Plan at Quality Committee • Assurance of CAVHIS Business Case Implementation in 2024/25

Strategic Risks – Quality

Equitable – We monitor performance against the actions outlined in the Equity, Experience and Patient Safety Framework and Action Plan. This goes to Quality Committee every six months. Our Cardiff and Vale Health Inclusion Service (CAVHIS) supports the most vulnerable people experiencing 'cliff edge' health inequalities, but there is more to do to support this population and reach out to the next level of people experiencing health inequalities. Investment has been agreed to support this expansion. Implementation of this Business Case will need to be reviewed periodically. Progress against the implementation of our co-production approach will also be important for improvements to equity. Our Shaping our Future Quality Excellence Programme is focussing on developing a Quality Management System for the UHB and on improving performance against specific quality challenges; Hospital Acquired Infections, Acute Deterioration, Lost to Follow-up and Medication Errors.	
Gaps in Controls	**Gaps in Assurances**
Lack of funding available for deliver planned care performance standards recurrently Both the clinical safety group and the clinical effectiveness groups are relatively new forums, and the Clinical Board quality and Safety governance needs to mature further to deliver a quality management system. Staff retention and recruitment vulnerabilities are impacting on case ascertainment for national audits. Many local improvements aligned to patient safety incidents are within the gift of the clinical boards to facilitate, however there are complex health board wide or national improvements for example delivery of scan for safety, implementation of a medical device register, whole system approach to observation and escalation that are dependent on resource Poor data collection on protected characteristics across the organisation.	• Approach to Quality Statements • Quality Outcome Framework • Resource for widespread health board wide improvements • Data improvements that will improve data monitoring of protected characteristics at the local level e.g. National Data Repository, a Population Health Management System for Wales and use of the NHS App in Wales

Risk Post-Controls and Mitigation			
Impact: 5	Likelihood: 3	Net Risk: 15	

Strategic Risks – Quality

Actions			
What	**Lead**	**By**	**Update**
Deliver stroke improvement plan to address quality concerns in acute stroke pathway	PB	31/12/25	• Business case approved for stroke model, funding to be released from Q4 2024/25 • Delays in recruitment for agreed stroke post • Recruitment is now underway to the additional posts, but it will be some time before all posts are in place. There is continued focus on stroke performance and a real increase in regional working to deliver sustainable models moving forwards. • Stroke performance remains stable – new SSNAP measures to be reported to Board in August. • Go-live of phase of regional thrombectomy service in July
Develop and deliver improvement plan for cancer and long waiting patients, including a plan to reduce diagnostic waiting times.	PB	31/03/26	• Delivery against revised trajectories is monitored internally and by WG • Challenging position in select specialities including ophthalmology • End of year positions in Cancer and 104 weeks for 24/25 good in comparison to recent years but still too long and not in line with WG expectations. Revised plans in place to deliver reduction during 2025/26 • Cancer performance remains best in Wales – further work to do to reach 75% • Long waits significantly reduced, meeting agreed trajectories for each quarter.
Develop and deliver long term proposal for ITU capacity – Strategic Outline Case in production	PB	31/12/25	• The design development continues. However, discussions are ongoing with WG in relation to a combined ITU/Haematology and Hybrid theatres schemes. • Interim plan for releasing capacity on 3rd floor in progress through discretionary capital programme – Work to C1 to accommodate Cardiology from C3 has commenced and is due to complete October 2025, releasing capacity ahead of the ITU work
Deliver the Theatres Together Programme which includes important quality elements such as the WHO checklist and productivity improvements	PB	31/03/2026	• Theatres Together Programme is underway, and updates provided through Board. Initial focus on 6 immediate actions and cultural priorities • Work on further tranches now underway
Review, design and improve mental health services which are noted to carry risks to quality	PB/DF	31/03/2026	• External consultancy appointed to support with review of mental health services – work ongoing • Plans for neurodevelopment services undergoing significant scrutiny
Development of a Quality Outcomes Framework- To support a data informed approach to quality	JR/ RS	31.06.25	• Meetings underway with corporate teams to agree quality indicators • Work to extrapolate data relating to patient safety incidents commenced • Plan to develop a first draft by Q1 with digital support by June 2025 • Publication of a UHB mortality dashboard • Publication and analysis of clinical board and directorate mortality dashboards

Strategic Risks – Quality

Development of the Quality prospectus to populate the quality academy – Up skill staff across the clinical boards in patient safety review technique, improvement planning and clinical governance	JR	31.03.26	• PSLR training developed • Improvement plan training in development • Human factor prospectus planning • Development of a quality academy • Accredited audit training in place
Monitoring of the Equity, Equality, Experience and Patient Safety Action Plan and progress against actions by Clinical Boards	CB	Every six months	• Paper for Quality Committee on progress against the action plan. • Early discussions with Public health around equity measures as part of the quality outcome framework

Shaping Our Future Wellbeing

Strategic Risks – Health Equity

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Health Inequity	Shaping our Population Health and Place Based Partnerships	Executive Director of Public Health	Quality	29 July 2021

Risk

There is a risk that lack of investment in prevention, primary care and community services coupled with a deterioration in the wider determinants of health will adversely impact our statutory duty to improve the health and well-being of our local population and our strategic ambition to reverse the historic trend in widening inequality in life expectancy for men and women living in Cardiff and Vale.

Cause	Impact
• People in the most deprived areas die earlier on average and live more of their lives in poor health; this is well recognised and deeply entrenched, but it is preventable. • People living in poverty are getting sicker and accessing services later. For the most deprived groups, EU attendances are nearly twice as high and emergency admissions more than double that of the least deprived. • In 2021 the *undiagnosed* diabetes rate was double for those in the bottom Indexe of Multiple Deprivation (IMD) quintile compared to the top.This presents a challenge for the NHS in finding those with an unmet need for healthcare. • Greater illness and poorer access to care (the inverse care law) contribute to worse health outcomes. This impacts directly on the gap in life expectancy between the most and least deprived groups. • Our organisation has set the strategic intention to shift spending from reactive care in hospitals to more prevention and proactive care in the community setting – but secondary care has attracted a greater share of NHS spending, meaning that prevention, primary care and community services have received a smaller share. This must be addressed for the sustainability of the organisation. Locally we call this left shift, a 'shift upstream' towards prevention. • Spending on prevention, and in primary and community settings had a superior return on investment when compared with acute hospital services. • There is strong evidence that areas that invest more in prevention and community care see 15 per cent lower non-elective admission rates and 10 per cent lower ambulance conveyance rates together with lower average activity for elective admissions and EU attendances. • Changing both the distribution of resources and the operating model to deliver integrated, preventative care closer to home are the strategic priorities of the	• We can reduce premature mortality, reduce social disparities, and reduce the absolute time in ill health. This in turn reduces the burden on the Health Board and social care while enabling our population to be more productive in our working lives, so strengthening the local economy. This is the desired outcome for individuals, families and the public purse. • Risk factors interact and multiple aspects of disadvantage come together, increasing the disease burden and widening equity gaps. • The key population groups with multiple vulnerabilities include: - Some minority ethnic groups, especially some people in Black and Asian populations - People living in (or at risk of) deprivation and poverty - People in insecure/low income/informal/low-qualification employment, especially women. - People who are marginalised and socially excluded, such as people experiencing homelessness and other inclusion health groups • Areas with higher unemployment have greater incidence of suicide; and people living in the most deprived areas experience the largest increase in mental illness and self-harm. • Health inequalities are estimated to cost £3-4 billion annually in Wales through higher welfare payments, productivity losses, lost taxes, and additional illness. • Lower levels of immunisation in the population have significantly increased the risk of outbreaks of diseases like measles. These will impact disproportionately more on our most deprived communities, with direct risks to health and by further negatively impacting on wider determinants such as education or employment. • The total annual cost associated with inequality in hospital service utilisation to the NHS in Wales is estimated to be £322 million, equivalent to 8.7% of the total hospital service expenses, driven largely by higher service use among people

Strategic Risks – Health Equity

organisation as described in the strategy, because they are derived from the changing needs of the population.

- Health inequalities are well documented across the UK, with a recurrent pattern of worsening outcomes linked to factors such as deprivation and ethnicity; these inequalities are evident for many chronic and acute conditions.
- Health inequalities arise in three main ways:
- structural issues, e.g. income, employment, education and housing
- unhealthy behaviours due to the environment, social norms and income levels
- inequitable access to, or experience of, services, which can be a result of discrimination due to inaccessible services, public information or healthcare sites that may be relevant/pertinent to particular needs.
- Differential experience of the wider determinants of health across the life course mean that disadvantage experienced in childhood is often compounded and exacerbated through adult life, and often passes inter-generationally.
- The 'Inverse Care Law' has been recognised for over 50 years, with those experiencing disadvantage consistently experiencing more challenges in accessing health services. Inequity of access to healthcare continues to be evident in Cardiff and the Vale of Glamorgan.
- Deprivation correlates strongly with rates of vaccination in the population, the gap in immunisation between the most and least deprived has been widening in recent years.
- The UHB also has a role as a care provider, employer and regional Anchor Organisation to positively impact the wider determinants of health for employees, patients and residents and to advocate for improvements to the wider determinants of health with other statutory partners.
- Lack of capacity to deliver evidence-based interventions at scale to tackle health behaviours e.g. smoking, diet, physical activity, alcohol, that drive the huge disparities in health outcomes we see across Cardiff and Vale.
- Lack of capacity to undertake more substantial work on the wider determinants of health with partners.

Lack of investment in prevention, primary and community services, e.g. health visitors (UK staff shortages) and public health consultants (Faculty recommends 15 for a population of 500,000).

living in the more deprived areas compared to those living in the least deprived (PowerPoint Presentation (nhs.wales)

- There is a moral and financial sustainability imperative to address health inequalities in our Health Board.

Uncontrolled Risk			
Impact: 4	Likelihood: 4	Gross Risk: 16	Target Risk: 12

Strategic Risks – Health Equity

Controls	Assurances
1. Statutory duty • The Health Board has a statutory duty: to improve the health and well-being of the local population. • The Socio-economic Duty places a legal responsibility on public bodies in Wales when they are taking strategic decisions to have due regard to the need to reduce the inequalities of outcome resulting from socio-economic disadvantage. • **2. Role as an Employer** • In our Equality, Inclusivity and Human Rights Policy, we have an active programme, which sets out the organisational commitment to promoting equality, diversity and human rights in relation to employment, and ensuring staff recruitment is conducted in an equal manner. • Our Strategic Equality Objectives and Plan 'Shaping our Inclusive Culture 2024-2028, has a number of key delivery objectives and is premised on the basis of embedding equality, diversity and human rights, and Welsh language, into UHB business processes. • All our Executives have taken up a leadership role as an Inclusion Ambassador covering different characteristics, including those specified in the Equality Act 2010. Staff have been signposted to resources to help them to cope with the cost-of-living crisis. **3. Our Strategy and Plans** • The refreshed UHB Strategy 'Shaping our Future Well-being' shines a light on the issue of equity at the strategic level. • The Cardiff and Vale long-term public health plan 2024 – 2035 sets out how the UHB intends to achieve its ambitions of increasing life expectancy, reducing inequity and shifting more focus to prevention. • 'Shaping our Inclusive Culture 2024-2028' is closely aligned with the UHB Shaping our Future Well-being. • Through our PSB and RPB plans we already prioritise areas of work to tackle inequalities and the refreshed needs assessments for both PSBs and RPB have further identified collective actions. • The future UHB organisational direction agreed at the recent rapid planning event supports the 'shift upstream' by committing to develop an Integrated Community Health System, underpinned by care pathways that begin with prevention; prevention is a 'brilliant basic'. • The establishment of a Strategic Diabetes Programme Board is a key element to reducing health inequalities and has an aim to identify those with undiagnosed diabetes in areas of deprivation across Cardiff and Vale. • The Health Board is implementing and periodically reviewing its strategy to tackle the lower and unequal uptake of vaccination in our most deprived communities. **4. Public Health Priorities to reduce health inequalities** • As a team we have agreed three immediate priorities that will influence health inequalities (and other work that we will need to bring forward when capacity allows):	Board papers Committee papers to Quality Committee e.g. updates on Equity, Equality, Experience and Patient Safety Framework. Committee papers to People and Culture and Quality and Safety Committees e.g. updates on Welsh Language Standards. Risk Registers Integrated Performance Report Papers to SLT

- preventing obesity (focus 0-5 years) - reducing smoking rates (dependent on a new business case) - increasing levels of vaccination (using an outreach model to reduce inequity in uptake).	
Gaps in Controls	**Gaps in Assurances**
	Monitoring data (e.g. on protected characteristics) Population Health Management System to reduce inequalities by identifying those at risk

Risk Post-Controls and Mitigation		
Impact: 4	Likelihood: 3	Net Risk: 12

Actions			
What	**Lead**	**By**	**Update**
Embed a 'Socio-economic Duty' way of thinking into strategic / operational planning, *beyond* complying with our statutory duty, and to always consider the unintended consequences of our actions	Claire Beynon/ Rachel Gidman	2025/26	• We plan to strengthen the strategic response to the Socio-economic Duty, ensuring actions are systematically applied. • The Equality and Health Impact Assessment (EHIA) process is being reviewed on an All- Wales basis with the view of creating a Once for Wales approach. C&VUHB will contribute to the development and implementation. The Health Board are also exploring opportunities as to how the EHIA process can be better embedded into governance processes and to make the process more user-friendly. • Our UHB will continue to work collaboratively with our stakeholders to shape our services and culture. • The UHB has now recruited an Equity & Inclusion Manager, who took up post in October 2025. This will improve organisational capacity to support Clinical and Service Boards, including with awareness and training on completing EHIAs. • ~~The UHB has recruited an Equity & Inclusion Manager who will start in October 2025, improving organisational capacity to support Clinical and Service Boards, including with awareness and training on completing EHIAs.~~
With the UHB and through our PSB and RPB partnerships, continue to develop and deliver a suite of focused preventative actions to tackle inequalities in health	Claire Beynon	March 2026	Work to tackle inequalities needs to take place over prolonged time periods. In 2025/26 we will continue to work with PSB and RPB partnerships to address the three priority areas where we know we can make a significant impact on reducing health inequalities: smoking, vaccination and obesity. The Amplifying Prevention Board, held jointly with Local Authority (LA) partners, provides governance oversight of this collective action and works to remove any blocks to collective action.

			• The Head of Equity and Inclusion is a member of the Public Sector Equality Network, improving the collaboration between public sector organisations in the area. • An ongoing, opportunistic programme of MMR vaccination catch ups will continue. ~~ until the end of the school year.~~ This programme is delivered in school and community environments, also using the vaccination van to support outreach efforts in communities with lower uptake. The wider community delivery model of vaccination is also continuing, with an enhanced focus on delivering vaccination closer to home. • A more targeted, intelligence driven approach is being discussed with Cardiff Council and appropriate data sharing agreements are under development. It is expected to take some time before the correct information governance will be in place to support ~~this, and~~this and a Task and Finish group meets fortnightly to maintain focus on this. Digital Health and Care Wales (DHCW) will support with automating the currently manual process of updating the school population data provided from Cardiff Council into the child health record system, CYPRIS. • The same intelligence driven approach is being used for analysing inequities of childhood vaccination in primary care. This work will help us to support General Practices in targeting and following up children in areas or communities with lower uptake. The Public Health Team's Data Analyst is developing dashboards that can be used to support discussions with individual GP surgeries in an accessible and interactive way. • ~~Operational plans are in place for the~~ Ddelivery of the injectable gelatine-free flu vaccination in the school setting is underway ~~during 2025~~. Community engagement activities are gathering insight on awareness of the gelatine-free options, and behaviourally informed communications, including an updated consent form, are being developed. • Our Health Improvement Officer works across Cardiff Council and the UHB's Public Health Team as part of a collaboration to improve our understanding of and engagement with ethnic minority communities. The aim of their work is to build trust with these communities, supporting us to understand and break down barriers to good health and wellbeing. The Officer is employed in this role by Cardiff Council, funded, via the Public Health Team, by a Welsh Government grant. • An 'Equity, Equality, Experience and Patient Safety' action plan was developed, covering 24 initial actions across the Clinical Boards that have strategic importance to delivering on the Equality, Equity, Experience and Patient Safety agenda. This was approved by Board in May 2024. Progress on the actions is reported to Quality Committee on a 6-monthly basis with the. The most recent update being was provided on August 5, 2025. As the actions are being completed, a review is beingwill be undertaken to identify further actions and steps. Highlights since the last update ~~from the most recent update~~ include: • ~~Progress has been made on the new health inclusion model based on need - there is a nurse in place between 9am-5pm to provide EU / ward in-reach. There is also a GP in place providing primary care in-reach to inclusion groups.~~ There are GP and nurse outreach clinics that have been newly established in the last 3 months into probation services and parlours. The outreach clinics into the frontline single

persons' hostels and the EU / Secondary care in-reach continue. Plans are in place to develop an outreach service in partnership with LA and third sector partners to Roma, Gypsy and Travelling people who present at unauthorised encampments.

- A national review of the Vaccine Equity Strategy has been completed and recommendations are being fed in to update the strategy. The Amplifying Prevention Board continues to be involved in the development of collaborative work to promote vaccination in schools and to address inequity in vaccination uptake.
- The Supporting Patients Whilst Waiting action has been implemented, and the team are expanding provision to more surgical pathways soon.
-

- People and Culture continue working on a number of initiatives to promote the UHB as an employer, aiming to build a workforce that genuinely reflects the rich diversity of the communities it serves.
- Work continues to meet targets in the existing plan, especially in relation to data collection to support data availability, linkage and analysis. A new action includes creating and developing an equity indicator dashboard. The next update on this work will be presented to the QSE in a further 6 months.

- Smoking is a major contributor to health inequalities; smoking prevalence is typically higher in areas of greatest deprivation and has a significant influence on morbidity and mortality. Using an NHS service such as 'Help Me Quit' can increase a person's chance of successfully quitting by 3 times. 'Help Me Quit' clinic provision is aligned with areas where smoking prevalence and deprivation are highest to help reduce barriers to service access. Further work is also planned to improve outreach e.g. with housing association tenants.
- Alongside more traditional advertising methods, innovative approaches to promoting 'Help Me Quit' are being trialled, including digital advertising in Cardiff city centre, 'in app' advertising direct to mobile devices, and partnerships with Cardiff City and Barry Town football clubs. In addition, the 'Help Me Quit' community service is working in partnership with local primary care practices and networks to take targeted action in deprived areas to promote smoking cessation services and encourage referrals and uptake amongst high-risk patient groups such as those with chronic respiratory diseases.
- Evidence shows that smokers are 36% more likely to be admitted to hospital than non-smokers. The 'Help Me Quit' service within Cardiff and Vale Public Health Team is working closely with the Hospital Smoking Cessation Service to maximise the opportunity to support *all* patients to quit, not only while in hospital but also long-term.
- There have been improvements made to the way that pregnant smokers are identified and contacted with stop smoking support. An 'opt out' process has been adopted (all pregnant smokers will be contacted by smoking cessation services unless they explicitly request for this not to happen).
- To support work on smoking cessation, partner organisations have shared materials, resources and information. This includes information on the introduction of the ban on sale of disposable vapes, and a new online resource to help people reduce vaping, and therefore dependence on nicotine.

			• ~~There have been improvements made to the way that pregnant smokers are identified and contacted with stop smoking support. An 'opt out' process has been adopted (all pregnant smokers will be contacted by smoking cessation services unless they explicitly request for this not to happen). The UHB's Community Smoking Cessation Services aim to ensure that clinic provision aligns to areas with higher smoking prevalence to reduce barriers to service access. Further work is also planned to improve outreach e.g. with housing association tenants. To support work on smoking cessation, partner organisations have shared materials, resources and information. This includes information on the introduction of the ban on sale of disposable vapes, and a new online resource to help people reduce vaping, and therefore dependence on nicotine.~~
Improve the routine data collection in relation to equality and inequity across the UHB.	Claire Beynon	March 2026	In 2025/26 there is an ongoing need to improve the routine collection of protected characteristics in order to support the introduction of new indicators. This will need to be addressed by each Clinical Board. Patient feedback is essential to improving service quality. Since October 2022, the UHB has collected most routine feedback via electronic surveys, accessed by SMS link, QR code and URL. We currently survey up to 1000 patients who have attended an outpatient appointment or following discharge as an inpatient every day; this includes the Emergency Unit (200), Mental Health (200) and the routine survey which randomly selects from all other clinical areas (600). As part of ongoing development, the routine survey has been translated into the top ten most frequently used languages, including BSL, English and Welsh. All surveys also collect information on protected characteristics, although this is not compulsory. Useful training tools and guidance are now available via the Health Board's sharepoint pages~~The next phase will involve rolling out useful training tools and guidance on the intranet~~ to support staff in engaging more effectively with patients and service users, helping them gather meaningful feedback about their experiences. This will be complemented by monthly feedback-in-focus sessions held across sites. Starting early 2026: A range of methods is used to gather feedback with the aim of ensuring all patients have the opportunity to contribute, including: • Website hosted surveys • Kiosk surveys • Tablet surveys • Postal surveys and paper-based feedback forms • Telephone surveys • SMS surveys • Focus groups • Patient stories

Strategic Risks – Health Equity

			• Bespoke • QR coded bBedside surveys The All-Wales Peoples Experience Framework was launched in April 2025. The new People's Experience Survey (PES) survey was implemented in May 2025 at the Health Board.

Strategic Risks – People

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
People	Shaping our People and Culture	Rachel Gidman	People and Culture	30 Sep 24

Risk

If we do not have the right people, the right culture and a healthy, effective workforce then we will not be able to provide the services to the population that we are required to and on which people depend.

Cause	Impact
1. Attract Recruit Retain • The increased demand across the NHS and Social Care has left a shortage in some professions and the sustained pressures have impacted negatively on wellbeing and retention. • National shortages in some professions have made it difficult to attract people with the right skills/experience and in the numbers required. • Attraction, recruitment and retention is also being affected by the negative image that is portrayed that NHS staff do not receive the right remuneration for the work that they do. The Industrial Action over the last couple of years has not helped the national reputation of the NHS as an employer. • People now think differently about work and what is important to them.	• Higher levels of sickness absence • Lack of management capacity to support staff appropriately; - Higher levels of turnover; - Low morale and poor staff engagement; - Increased reliance on temporary workforce e.g. bank, agency, locums, etc; - Reduced capacity to undertake appraisals, identify development needs, and focus on talent management and succession planning. - Lack of capacity to upskill and develop our current workforce. - Reduction in uptake of student training places and higher attrition rates, resulting in a reduction of graduates. • Potential negative impact on quality of care & safety. Inability to expand services as required due to lack of staff with the relevant experience, skills, etc.
2. Culture • There is a belief within the organisation that the current climate is high in bureaucracy and low in trust. • Staff reluctant to engage with the case for change as they are overwhelmed with system pressures, change and ongoing demands. • Staff are not feeling involved in, or understanding the part their role plays for the case for cultural change due to lack of communication filtering through all levels of the UHB. • Additional complexities as colleagues continuously respond to the challenges of the pandemic, making involvement in, and response to change complex and challenging.	• Staff morale may decrease • Increase in absenteeism and/or presenteeism • Difficulty in retaining and recruiting staff • Potential decrease in staff engagement • Increase in formal employee relations cases / respect and resolution • Transformation of services may not happen due to staff reluctance to drive the change through improvement work. • Patient experience ultimately affected. • UHB credibility as an employee of choice may decrease • Staff experiencing fatigue and burnout making active and positive engagement in change challenging and buy-in difficult to achieve. • Existing inequalities exacerbated • Not realising the opportunities within workforce sustainability

Strategic Risks – People

3. Wellbeing • Lack of integration and understanding of importance of wellbeing amongst managers • Impact upon manager wellbeing of balancing staff and service needs • Conflict between demands of service delivery and staff wellbeing • Exposure to psychological impact of increasingly complex and challenging demands of care • Inability to deliver care to required standard due to short staffing (moral injury / moral distress) • Ongoing demands over an extended period of time • Cost of living • Financial climate	• Values and behaviours of the UHB will not be displayed due to high pressure environments, and potential for exacerbation of existing poor behaviours • Operating on reduced staff levels in clinical areas due to sickness absence and/or staff shortages • Mental health and wellbeing of staff will decrease, existing MH conditions exacerbated • Clinical errors will increase • Staff morale and productivity will decrease • Job satisfaction and happiness levels will decrease • Increase in sickness levels • Patient experience will decrease • Increased referrals to Occupational Health and Employee Wellbeing Services (EWS) • Increased referrals for higher level psychological support • UHB credibility as an employer of choice may decrease • Potential exacerbation of existing health conditions Impact on retention (negative) and attraction of staff into healthcare

Uncontrolled Risk			
Impact: 5	Likelihood: 4	Gross Risk: 20	Target Risk: 10

Strategic Risks – People

Controls	Assurances
• The People and Culture Committee provide more scrutiny and assurance to Board. • People and Culture Plan in place with a robust governance structure monitoring delivery against the agreed priorities. • Monthly Executive Review meetings with Clinical Boards • Strategic oversight meetings, e.g. NPG, MWAG and introduction of MPG (Medical Performance group) • Cardiff and Vale UHB refreshed strategy: Shaping Our Future Wellbeing • Talent management and succession planning framework • Values based recruitment / appraisal • Strategic Equality Plan • Anti-Racist Action Plan • Workplace Race Equality Standards (2024) • Welsh Language Standards • Patient experience score cards • Raising concerns procedure/Speaking up Safely. • Widening Access Framework • New Starter Surveys and Exit Questionnaires/interviews • Nursing Staff in Post Forecasting to identify potential risks in advance Adoption of consistent, evidence-based approach to Culture and Leadership via the NHSE Culture and Leadership Programme Staff survey	• Robust monitoring of People and Culture Plan KPI's at the People and Culture Committee and Board. (1) • Quarterly IMTP/Annual Plan updates to WG. • WG JET and IQPD • Effective partnership working with Trade Union colleagues (WPG, LNC, LPF). • Internal Audit on Staff Wellbeing, Culture and Values (Sept 2022) report (3); • Engagement of staff side through the Local partnership Forum (LPF) (1) Matrix of measurement now in place which will be presented in the form of a highlight report to Committee (1) • Internal monitoring and KPIs within the OH&EHWS (1) • Wellbeing champions normalising wellbeing discussions (1) • VBA focussing on individual wellbeing and development (1) • Successful retention of the gold (and platinum) Corporate Health Standard awards via the 'Enhanced Status Checks' in March 2023 • Substantive funding identified to maintain on a permanent basis the enhanced EWS service from April 2023 • Development of a new and permanent OD Manager - Wellbeing and Engagement role • Taking Care of Carers Audit and Action Plan to become part of Business as usual (3) • Internal audit on Staff Wellbeing, Culture and Values (September 2022) Report and implementation of Management Actions (3) • Trade unions insight and feedback from employees (2) • Working with HEIW as part of the Financial Wellbeing (FWB) task and finish group to develop a FWB strategy for NHS staff in Wales (2)
Gaps in Controls	**Gaps in Assurances**
Agreed Retention Plan for all staff. Retention & OD Lead for the UHB • Workforce supply affected by National Shortages. No leadership / management principles as a UHB (currently align with HEIW compassionate leadership principles) • No organisational cultural dashboard	Capacity to respond to requests for cultural and transformation work Effective measures of culture / engagement • Organisational acceptance and approval of wellbeing as an integral part of staff's working life balanced against demand and flow • Awareness and access of employee wellbeing services, particularly for staff without email / internet access

• Staff shortages / industrial action leading to movement of staff and high demand for cover • Transparent and timely Communication especially to staff who do not have digital access • Continued increase in manager referrals to Occupational Health • EWS seeing an increase in staff presenting with more complex issues, including a rise in referrals needing a wellbeing check due to the presentation of high risk in the referral • No Colleague Health and Wellbeing Framework	• Clarity of signposting and support for managers and workforce

Risk Post-Controls and Mitigation		
Impact: 4	Likelihood: 4	Net Risk: 16

Actions			
What	**Lead**	**By**	**Update**
Agreed Retention Framework to support retention for all staff groups, aligned to HEIW Principles and HEIW Nurse Retention Plan. Attract, Recruit and Retain is one of the key three themes of the People and Culture Action Plan which is monitored on a monthly basis to ensure good progress.	Claire Whiles	Oct 2025	• The All Wales self-assessment was due on the 31 March 24. The organisation completed and submitted. • Draft OD, Wellbeing and Culture Framework and Toolkit produced and under review. To be ready for publication and engagement October 2025. • The annual Defence Career Transition Partnership event was held at Cardiff City Stadium on Wed 5 Nov 25. This event serves 2 x purposes, to attract Service leavers at a recruitment fair and to build better relationships between the Armed forces and Health. There is ambition to increase the employment of service leavers/reservists into CAVUHB who will come with a suite of strong L&M skills. • Ambition is to softly prepare CAVUHB to support the Strategic Defence and Security Review(SDSR) by better aligning Health and Defence in Wales. (WG aspiration) •
To develop management and leadership development where compassionate and inclusive leadership principles will be at the core of all the programmes.	Claire Whiles	Oct 2025	• Management programmes continue to be delivered and evaluated using the Kirkpatrick model (introduced Q1 2024). Lessons learned is part of the ongoing L&M Review.

Strategic Risks – People

			• Compassionate Leadership masterclasses developed via 'train the trainer' session with Professor Michael West. Delivered regularly. Ongoing review and evaluation in place. Lessons learned is part of the ongoing L&M Review. • Leadership, Management and Skills programme for Band 8C and 8B (Optimising Ops) agreed and ~~will~~ commenced in September 2025 for 8C managers. ~~Exploring regional delivery with~~ 2 x ABUHB deliegates are attending, demonstrating ~~and CTMUHB to enhance resilience, content and~~ mutual support, shared and regional working. • Elev8 Programme to be launched September 2025 to support Advancing Clinical Leadership. A multi-disciplinary programme to support Band 7 clinical leaders in order to successfully lead compassionate, accountable and improvement focused teams. . • ~~Successful recruitment to Head of Leadership and Management position, individual will commence in role October 2025. Work continuing until that time, overseen by Head of OD and Culture. We continue to work closely with HEIW to align leadership principles to 4-nations work on leadership and management competencies. Focus on management development focused on brilliant basics - managing attendance and wellbeing, accountability and ownership, compassionate leadership~~ • Hd of L&M appointed wef 29 Sep 25 – new role that will increase capacity within L&M team and contribute to development of a new strategic L&M plan • New HEIW led Leadership and Competency Framework due to be rolled out across Wales in the net 1-3 yrs (based on NHS England work) • Deep dive of existing L&M packages underway to ensure we are aligned with HEIW leadership principles and expectations. • Analysis underway of a new strategic L&M plan to ensure it aligns with other P&C work , WG and Future Generations expectations and is mutually supportive. • Collaboration with DHI commenced to develop additional offers using a joint capability to improve effectiveness across the system. This mitigates seeking costly external trg delivery i.e Self, Team, Team of Teams (STATT). • HEIW Audit of L&M confirmed for Feb 26. Review of previous advisory in Jul 2023 has been undertaken and preparation for the audit is underway.

			• All programmes underpinned by compassionate and inclusive leadership principles and aligned to the all-Wales leadership competencies and principles. • Connected to Isle of Wight and Portsmouth NHS Trusts to identify key learning around the Culture and Leadership Programme. Two meetings held to date, documents reviewed and key learnings considered. • 'Cultural Safety Zones' concept being taken to 'Spread and Scale Academy' in October 2025, 6 key stakeholders presenting work. This links to Culture and Leadership Programme, Ward accreditation, Service Reviews and Compassionate Leadership Pledge. Supported by TU partners. • Thorough TNA will be required to support effective leadership and management development. Looking at Management Passport for all managers to ensure underpinning knowledge. This work is ongoing. • ~~Self, Team and Team of Teams pilot leadership programme delivered to Peri-Natal Colleagues April 2025. Evaluation with HEIW to review next steps.~~
Equality, Diversity and Inclusion	Claire Whiles	~~Oct~~Dec 2025	• Continue to monitor the delivery of the Strategic Equality Objectives and Plan through annual reporting.
Welsh Language Standards being implemented.	Claire Whiles	~~Oct~~Dec 2025	• Continue to improve capture of Welsh language skills data through 'making every contact count' approach (i.e. Staff Survey roadshows). ○ Current registration is ~~53.7~~58.7%, an increase of 8.18~~5.08~~% from ~~August~~October 2024 to ~~August~~ October 2025. • Resolve the three Standard Enforcement Investigations currently open with the Welsh Language Commissioner. • ~~Concern raised by Welsh Language Commissioner regarding signage in Neonatal Clinic in UHW has been resolved.~~ • Assurance provided to Welsh Government on implementation of the More than just words national strategy in the IQPD review in October 2025. • Continue to communicate and deliver Welsh language learning opportunities with Dysgu Cymraeg Caerdydd.
Inclusion - Nine protected Characteristics	Claire Whiles	~~Oct~~Dec 2025	• LGBTQ+ Action Plan development on pause due to capacity, to be revisited ~~and re-energised upon commencement of E&I Manager in October 2025~~ once guidance received from the Welsh Government on implementation of Supreme Court ruling on definition of sex.

			• ~~I~~WRES report received by UHB, currently being reviewed and meeting with Welsh Government planned for 15 September 2025 to discuss findings and proposed actions. Papers will also be taken to SLT and P&C Committee • UHB met with Welsh Government on 15 September 2025 to discuss findings of WRES report. WRES papers presented at People and Culture Committee, Senior Leadership Team, and Local Partnership Forum. • ~~Re-assessment taking place to~~ UHB retained Disability Confident Leader (Level 3) status in October 2025.
Commissioning model / whole team approach introduced in People and Culture to ensure managers / teams can request support / advice / guidance and training which is delivered / supported by the most appropriate team / individuals and/or external partners. Includes representation from ECOD, People Services, Wellbeing Services, Equity and Inclusion.	Claire Whiles	September 2025	• Connect to current review of L&M packages. • Feasibility assessment being undertaken to understand what on;the-shelf trg can be approved by L&M team but delivered by Team leaders/managers across the organisation • Feasibility review being undertaken to understand if existing L&M team has capacity to deliver/create bespoke trg for the organisation whilst concurrently implementing the new competency leadership framework. • People and Culture Team working in collaboration with HEIW and Professor Michael West to review and improve culture and leadership programme implementation, monitoring and evaluation. Measures to be established and lessons learnt internally and via NHS England to be under-taken. Meeting with Portsmouth and Isle of Wight NHS Trusts has taken place and shared documents and reports in review. • P&C MDT established and reviewing organisational requirements in interim. Priority setting meeting scheduled for August 2025. • Priority cultural work currently identified and allocated by Chief Operating Officer, EDofP&C and appropriate Executive Directors. Elements of work paused due to Service Review requirements, but action plans now shared and OD/P&C input identified and in planning stage. • Progreess on OD, Wellbeing and Culture Framework detailed above.
The People and Culture Team will identify insights from workforce data, including themes emerging from EWS, OH, People Svcs, Culture work and Staff Survey, to shape strategic and operational response to themes / emerging trends. This will also be informed by working in collaboration with Clinical Boards.	Claire Whiles	August-Oct 2025	• Developments required to P&C Dashboard to ensure include all relevant measures, e.g. OH and EWS KPIs. Working with HEIW to improve dashboard reporting. • OH KPIs regularly reported to WG and KPIs adjusted to align with Welsh Government guidelines (i.e. calendar days). Collaboration review scheduled for September 2025. • Internal audit of OH Services moved to Quarter 3, 2025 at request of Audit Team.

			• NHS Wales Staff Survey 2024 reporting at CB Exec Reviews and SLT. Engagement in 2025 NHS Wales Survey commenced August 2025 in readiness for launch in Oct 2025. Thorough engagement and communication plan supported by P&C Team and TU Partners. • OPAS database implementation underway in EWS to support effective reporting and user experience. Licences procured, in initial stage of handover..
1. Enhance communication methods across UHB - Social media platform - Regularity and accessibility of information and resources Improve website navigation and resources	Claire Whiles	Oct 2025	• Draft OD, Wellbeing and Culture Framework and Toolkit produced and under review. To be ready for publication and engagement October 2025.People Health and Wellbeing Services currently reviewing sharepoint pages for staff following move to Woodland House and staffing changes to ensure most up-to-date information available. Working closely with Public Health Team to ensure consistent engagement around health priorities, including vaccination.
2. Training and education of management - Integrate wellbeing into all parts of the employment cycle (recruitment, induction, training and ongoing career) Enhance training and education courses and support for new and existing managers	Claire Whiles	Oct 2025	• Connect to review of all existing org L&M trg packages(above). This includes adding more EDI trg into trg packages as EDI contributes to improvement in wellbeing. • L&M Back-to-basics plan, which is being developed will contribute to improvement of wellbeing • Colleague and Manager wellbeing included in all management and leadership programmes, induction. • This is included within leadership and management principles development and leadership programme development as above. • Management training under review and refresh to focus on wellbeing and keeping people well at work. Managing Attendance at Work training reviewed and re-launched April 2025, supported by digital learning. Positive responses to training to date – e-learning element due for launch September 2025 following review. • Successful recruitment into Head of Leadership and Management post, role will enable distinct focus on development of existing and future leaders and managers. To commence Oct 2025. • Elev8 Programme to be launched to support Advancing Clinical Leadership in September 2025. A multi-disciplinary programme to support Band 7 clinical leaders in order to successfully lead compassionate, accountable and improvement focused teams. . •

Strategic Risks – People

Wellbeing interventions and resources to be evidence based, targeted, reviewed and evaluated.	Claire Whiles	November 2025	• EWS continue to offer evidence based interventions and review and enhance offer, e.g. Spring; EMDR • Operating model review and 3 year plan to be developed to support delivery of the People and Culture Plan and organisational priorities, including trauma informed support and pathways. • Service currently impacted by staffing shortages (sickness absence), this is affecting reporting and administration. Team working together to resolve. • Improvement required across UHB to ensure consistency of offer, e.g. Trauma response / psychologist intervention / evidence based practice. Paper developed and to be presented to Management Executives in first instance. • Staff Fast Track Trauma Pathway under review due to increase in waiting times, proposal within paper as outlined in bullet point above. • Communications and education around Trauma Pathway to be enhanced following feedback and collaboration with the Trauma Pathway Multi-Disciplinary Team. • Trauma Risk Management (TRiM) proposal presented at Senior Leadership Board for feedback, business case in development for presentation as part of paper detailed above. • Review of EWS and OH service based upon direction of 'Brilliant Basics' to align to organisational priorities and support reduction in waiting times. To follow collaboration review (October 2025)

Strategic Risks – Digital

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Digital	Shaping our Future Digital Services	Director Digital and Health Intelligence (D&HI)	Digital and Infrastructure	4 October 2022

Risk

CAVUHB has legacy and deficit in human resources, skills and capability, infrastructure, applications and informatics. The digital estate has grown but the supporting resource has not. Without resourcing our Digital and Data transformation plans and Roadmap we risk the achievement of our SOFW objectives

Cause	Impact
CAVUHB IT and digital services are known to be historically underfunded resulting in a legacy and deficit in infrastructure, applications and informatics capability that has built up over at least a decade (e.g. our core applications for UEC, inpatients and outpatients were developed in-house-c20 years ago). There are plans to rectify these issues however they are unachievable with the current resource (people, finance) allocation We have some capability in human resources but insufficient capacity or funding to execute the digital and data transformation plans and road map. Existing resources are fully consumed with tactical short-term on the day-to-day urgency of UHB operational needs Recruitment of suitably skilled D&HI staff is a national challenge as well as affecting CAV. This often requires the use of interim agency support in key areas, especially whilst we continue with legacy solutions as we are tied to old technologies. This of itself diminishes further our existing capacity as resources need to be familiarised with the technical environment and then supervised. Historically CAV has looked to provide much of its core IT and digital services inhouse. This is not always necessarily the optimum route however 'legacy lock' and the resource to support forward plans keeps us where we are. Meanwhile with new initiatives the technical estate grows and the gap between what we have and what we can support/refresh widens.	Colleagues need mobile, scalable, agile solutions that enable data collection and sharing. This is unachievable whilst we are locked into legacy. Legacy Lock makes improving our cyber posture more challenging (e.g. securing our data) The impact of not managing this risk is that the improvements in safety, quality, outcomes, productivity and financial efficiency that staff and patients expect from D&HI cannot be fully realised, therefore putting at risk the deliverability of the SOFW Strategy.

Strategic Risks – Digital

Uncontrolled Risk			
Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 20

Controls	Assurances
• Digital strategy approved by Board in 20/21 with roadmap for 21/22/23 - these will be refreshed by April 2025 • Roadmap to support the strategy shared with DHIC covering 2024/27 - these will be refreshed by April 2025 as part of the Digital Foundations PBC work • Digital components described in IMTP – focussed on in year national and clinical board priorities • £466K is being invested by CAVUHB in the development of a Digital Programme Business Case (PBC) to seek All Wales Major Capital Funding alongside a Business Justification case (BJC) for phase 1 of the 5 annual phases. This work will complete in 12 months. • The work will deliver a clear trajectory, costs and plans on how CAV will achieve its target of HIMSS[1] Level 3 in pursuit of its intention towards a modular EPR, consistent with national and regional initiatives. The capabilities the PBC and business justification cases will describe are harmonious with and would segue into any nationally agreed and funded EHR solutions through interoperability and concordance with the "All Wales" Infrastructure review. ○ Work is expected to begin Oct/Nov 2024. ○ This follows positive discussions with WG IIB and NHS CDIO,	• All Controls are shared and discussed with the DHI Committee which meets quarterly. • The Digital Foundations case was scrutinised and approved by the Investment Group and Strategic Leadership Board. • The Director D&HI shared the intentions of the Digital Foundations investment case and updated WG's chief digital officer, whilst the DoF has discussed with IIB Lead. Both are supportive of approach and our intentions • Recruitment and procurement is underway for the resource to produce the PBC and BJCs • Risk register articulates the risks of not being able to deliver digital solutions to support delivery of healthcare (1) • Internal audit report highlights the risk in delivering digital strategy citing the investment challenges that will prevent full implementation.

Gaps in Controls	Gaps in Assurances
Current annual discretionary funding is insufficient to cover the maintenance upkeep of the core infrastructure and there is no headroom for innovation	Unable to currently provide assurance that the finance will be provided

Risk Post-Controls and Mitigation		
Impact: 5	Likelihood: 4	Net Risk: 20

Strategic Risks – Digital

Actions			
What	**Lead**	**By**	**Update**
Internal investment case to support the Digital Foundations case approved	Director of DHI	Sept 25	Programme Business Case completed and shared with WG setting out detailed roadmap plans and the associated costs, funded accessed by annual Business Justification Cases to WG's Major capital budget. Statement of works produced against which a suitable external partner will be sought Digital Foundations Programme Business Case and supporting Business Justification Cases for Year 1 (of the 5 year case) complete. PBC being taken through the internal governance process comprising Capital Management Group, Value & Benefits Realisation Group, Senior Leadership Team, F&P and D&I committees before presenting to the November Board meeting and thereafter submission to Welsh Government for their consideration/approval.
Development of the Digital Programme Business case to support the digital foundations ambitions is underway.	Director of DHI	Dec 25	External partner identified and service procured which has enabled the works to commence on the Programme Business Case. Co-production approach with all Clinical Boards and corporate services involved via workshops taking place during May and June 2025. July 25: Draft plans and outputs from workshops shared with Clinical Boards for comment prior to feeding into the Programme Business Case in Sept/October 25. Digital Foundations work to support the development of the Programme Business Case and supporting Year 1 Business Justification Cases complete. Workshops held with input from all Clinical Boards and services to ensure full co-production and alignment with the organisation's strategic objectives.

Strategic Risks – Infrastructure

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Infrastructure	Shaping our Future Infrastructure	Exec Dir Finance	Digital and Infrastructure	12 November 2018

Risk

There is a risk that the condition and suitability of the UHB estate, IT infrastructure and Medical Equipment impacts on the delivery of safe, effective and prudent health care for the patients of Cardiff and Vale UHB.
The condition of facilities within our main hospitals and some community facilities are impacting on our ability to continue to provide the full range of services and provide the would like to commission from us. This is as a result of insufficient funding and resource to bring the estate up to the required condition in a timely way.

Cause	Impact
• Significant proportion of the estate is over-crowded, not suitable for the function it performs, or falls below condition B (assessed regularly on an all-Wales basis by NHS Shared Services Partnership). • Investment in replacing facilities and proactively maintaining the estate has not kept up the requirements, with compliance and urgent service pressures being prioritised. • Lack of investment in IT also means that opportunities to provide services in new and efficient ways are not always possible and core infrastructure upgrading is behind schedule. • Insufficient resource to provide a timely replacement programme, or meet needs for small equipment replacement • Lack of timely decisions regarding the development of strategic business cases required to address the significant estates challenges we face.	• The health board is not able to always provide services in an optimal way, leading to increased inefficiencies and costs. • Service provision is regularly interrupted by estates issues and failures. • Patient safety and experience is sometimes adversely impacted. • • Medical equipment replaced in a risk priority order where possible, insufficient resource for new equipment or timely replacement • Staff facilities needed to support good staff wellbeing are inadequate in many areas.

Uncontrolled Risk

Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 15

Strategic Risks – Infrastructure

Controls	Assurances
• Estates strategic plan in place which sets out how over the next ten years, plans will be implemented to secure estate, which is fit for purpose, efficient and is 'future-proofed' as much as possible, recognising that advances in medical treatments and therapies are accelerating. This is being updated. • Statutory compliance estates programme in place – including legionella proactive actions, and time safety management actions. • The strategic plan sets out the key actions required in the short, medium and long term to ensure provision of appropriate estates infrastructure. • The annual capital programme is prioritised based on risk and the services requirements set out in the IMTP/annual plan, with regular oversight of the programme of discretionary and major capital programmes. The 2025/26 Capital Plan will be submitted for Board with the IMTP • Medical Equipment prioritisation is managed through the Medical Equipment Group and there is a process in place for rapid decision making if there is a urgent need to replace a piece of equipment. This part of the Capital Management Group agenda. • Business Case performance monitored through Capital Management Group every month and Finance & Performance Committee at each meeting, every month. • Welsh Government has asked all NHS organisations to provide a prioritised capital programme using a weighting framework developed by the Infrastructure Investment Board. The submission date is 31st March 2024. The Health Board's submission has been scrutinised and approved through the internal governance mechanisms and is coming to the Board on 28th March for oversight. • The outcome of the WG prioritisation process was confirmed and the schemes which they have indicated support include The Vascular/MTC theatres, Haematology including BMT and ITU refurbishment. Following discussions with WG colleagues the UHB are developing options for the delivery of these projects which could include an integrated new build facility. • Discussion with Welsh Government regarding the Shaping Our Future Acute Hospital Programme continues, albeit that there has been somewhat of a hiatus over the last 9 months. The initial focus will be on the delivery of a master planning exercise to determine the most appropriate direction of travel to deliver new facilities to support the delivery of clinical services into the future. The tender documentation and specification is being finalised with the intention to procure a supplier by the end of 2025.	• The estates and capital team is in constant dialogue with WG and continues to present business cases to secure the necessary capital to address the major short/medium term service estates issues. This has proven successful in the closing months of the financial year A significant amount of end of year funding has been secured, as in previous years, and this has enabled capital investment in critical digital infrastructure in particular. • The statutory compliance areas are monitored every month in the Capital Management Group to ensure that the key areas of risk are prioritised and reporting of estates risks to the Health and Safety Committee has been strengthened(1) • The Executive Director of Strategic Planning and the Director of Capital, Facilities and Estates meet regularly with the Welsh Government Capital Team to review the capital programme and discuss the service risks (3). • Regular reporting on capital programme and risks to Capital Management, Management Executive and Finance & Performance Committee (1) (2) •) • Health Care Standard completed annually (3) • Medical equipment risk registers developed and managed by Clinical Boards, reviewed at UHB medical equipment group (1) (2) • Finance and Performance Committee continue to oversee the delivery of the Capital Programme (1) • A way forward in relation to the Shaping Our Future Hospitals Strategic Outline Case is being progressed by the Health Board(3) Risk Register reporting to D&I Committee

Strategic Risks – Infrastructure

Gaps in Controls	Gaps in Assurances
• The current annual discretionary capital funding is not enough to cover all of the priorities identified through the risk assessment and IMTP process for the estate and medical equipment replacement services which requires the need to prioritise investment and resource allocation based on assessed level of risk and alignment with strategy and IMTP priorities. • In year requirements further impact and require the annual capital programme to be re-prioritised regularly. • Traceability of Medical Equipment • The Welsh Government current capital position is very compromised due to size of budget compared with estimated need which will impact significantly on the Capital Programme of the UHB. Not all business cases in the Welsh Government capital plan will be deliverable and the UHB needs to be mindful of the potential reputational risk of delays between OBC and FBC approvals with supply chain partners.	• The regular statutory compliance surveys identify remedial works that are required urgently, for which there is no discretionary capital funding identified, requiring the annual plan to be re-prioritised, or the contingency fund to be used. • Medical equipment is also subject to regulatory requirements, and therefore requires re-prioritisation during the year. • Despite the substantial end of year capital, the recurrent position remains unchanged. • Full condition surveys of all buildings have not been carried out so not possible to fully understand the condition of the estate.

Risk Post-Controls and Mitigation		
Impact: 5	Likelihood: 4	Net Risk: 20

Actions			
What	**Lead**	**By**	**Update**
Risks to infrastructure which have been identified are developed into robust plans for mitigation. These are prioritised through our annual planning work and identified	Geoff Walsh	Annual plan	The discretionary capital is prioritised to meet our annual plan. Prioritised plan is signed off by CMG and SLB and Board. Significant risks or financial requirements are raised regularly with Welsh Government to support when necessary. WG Targeted Estates Funding received which will address some of the highest risks identified on the CEF Risk Register. Schemes which received approval have been reported to CMG and SLB
Where estate is no longer required for the provision of care or services a programme of decommission, disposal or demolition is undertaken to minimise the estate and infrastructure which the Health Board needs to maintain.	Geoff Walsh	Annual plan	Decommission priorities – Denbeigh and Carmarthen house have been vacated, and planning permission is being sought for their demolition, along with Brecknock House and the recently vacated Sports and Social club CEF are working with the Specialist Clinical Board on options to re-locate ALAS and deliver a single site option for the service Disposal plans – Rookwood the UHB have identified a preferred bidder following a comprehensive disposal exercise and are working with them to develop the proposal, including Heads of Terms etc.

Strategic Risks – Infrastructure

A condition survey will be undertaken to understand in detail the status of the Health Board estate with a view to inform a future investment priorities and estate needs.	Geoff Walsh	December 2025	The scope and plan for the condition survey have been shared with and supported by Welsh Government. The site survey work has progressed well and, the delivery of the final report is due by the end of 2025.

Strategic Risks – Sustainability

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Sustainability	Shaping our Future Generations	Exec Dir Finance	Finance and Performance	1 April 2022

Risk

If the organisation cannot produce a balanced 3-year plan or a balanced IMTP in any year it will breach its statutory financial duty and will be limited in the ability to deliver on the strategy and so the services to the population that the organisation serves.
If the organisation cannot protect the environment and take the steps required of it regarding waste, carbon footprint and other deliverables, it will not be an efficient service and will jeopardise the health of future generations.

Cause	Impact
Finance The UHB has to manage its operational budget. In the absence of a 3 year approved IMTP the UHB works to One Year Operational Plans from year to year. These still require significant savings achievements within each financial year irrespective of a deficit year end projection. Decarbonisation The UHB has to achieve 16% and 34% emission savings from a 2018/19 baseline by 2025 and 2030, respectively, aligned with Welsh government targets. Additionally, the "Shaping Our Future Wellbeing" strategy targets a 40% reduction in directly controlled emissions by 2027. In 2024-25 the UHB's emission has increased by 44% to c260,000 Tons of Co2 compared to 2023-24 emission of c180,000. **The UHB has already missed Welsh Government target of reducing its emission by 16% by 2025.** Climate Impacts: The world has breached the 1.5°C pathway set by the Paris Agreement in 2024. Growing evidence shows that the magnitude of climate impacts is increasing day by day, and Cardiff is projected to be one of the most affected cities in the UK.	Breach of statutory duties, escalation. Unable to deliver a balanced year-end financial position. Reputational loss. Inefficient or reduced service delivery Decarbonisation and Climate Impact Risks: Strategic Risks: CAV UHB is not in line of sight of achieving neither Welsh Government targets nor targets set by Shaping Our Future Wellbeing Strategy as our emissions are increasing, in 2024-25 the UHB's emission has increased by 44% to c260,000 Tons of Co2 compared to 2023-24 emission of c180,000. **The UHB has already missed Welsh Government target of reducing its emission by 16% by 2025.** Operational Risks: Initial findings from our ongoing heatwave survey reveal that **80% of staff reported high levels of discomfort, with 32% experiencing health effects during recent heatwaves**. Preliminary analysis of climate data also indicates a projected increase in the frequency and intensity of heatwaves. These figures underscore the urgent need to protect our workforce and adapt our care environments to ensure resilience in the face of escalating climate risks. Financial Risks: The impact of climate change on the UHB is multidimensional and cascading. Initial findings from the heatwave survey indicate a **~30% of clinicians have observed an increase in**

Strategic Risks – Sustainability

The Welsh government has made it mandatory for UHB to submit an annual qualitative report on climate adaptation. Currently, UHB has not undertaken a comprehensive assessment of current and future climate risks. This renders UHB vulnerable to unidentified climate risks that have a direct impact on healthcare delivery and its financial situation. Resource Risks: CAV UHB has just limited resource for Sustainability and Climate response, this will impact on embedding sustainability and building climate response.	**patient footfall during and immediately after heatwave periods**. Additionally, there were reports of extended patient length of stay, attributed to poor rehabilitation outcomes and delayed recovery. These are just some of the emerging consequences. With the projected increase in the frequency and intensity of climate events, such impacts are expected to intensify, ultimately leading to a greater financial strain on the Health Board. Legal Risks: Across the UK, public sector organisations and local authorities are increasingly facing legal action for failing to take sufficient steps to meet their emission reduction targets and to adapt to the changing climate. CAV UHB's current trajectory of not meeting its emission reduction targets and showing slow progress on climate adaptation could expose the organisation to climate litigation risks.

Uncontrolled Risk			
Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 10

Controls	**Assurances**
Additional expenditure is being authorised within the governance structure and the UHB Scheme of Delegation. Financial Plan submitted to Welsh Government in March 2024 explaining inability to deliver financial balance over the three-year period 2024-2027. The Savings programme is managed through weekly Senior Leadership Team and a series of Financial summit events chaired by CEO aligned to the National Value and Sustainability Board and the annual planning framework enabling actions Decarbonisation A decarbonisation action plan is in place to deliver decarbonisation actions aligned with the NHS Wales Decarbonisation Strategic Delivery Plan 2021-2030. SusQI has been implemented to embed sustainability in Q&I projects.	The financial position is reviewed by the Finance & Performance Committee which meets monthly and reports into the Board (1) Financial performance is a standing agenda item monthly on Senior Leadership Team with escalation to Management Executives Meeting (1) Financial performance is monitored by the Management Executive (1). Assurance from internal audit annual review of core financial controls including budgeting and planning. Senior Leadership Team is now weekly to ensure savings delivery, chaired by the Chief Executive. Additional measures implemented IY as set out in actions below Decarbonisation plan is developed annually and overseen by Finance and performance committee

Strategic Risks – Sustainability

The Welsh Government has mandated yearly reporting, such as Decarbonisation Co-Ordination Reporting and Emission Reporting, along with all other health boards in Wales. Climate Impacts The Welsh Government has made it mandatory to report qualitatively on progress regarding climate adaptation. A task and finish group has been established to identify pathways for climate risk assessment and climate adaptation pathways. Initial conversations are being held with the MET Office to collaborate and conduct a comprehensive Multi-Risk Assessment, starting with the impacts of heatwaves on our operations.	
Gaps in Controls	**Gaps in Assurances**
Decarbonisation The current financial landscape doesn't allow UHB to meaningfully develop plans to hit NHS Wales targets or the targets set out by the strategy. Given the complexity of decarbonisation actions across various departments of the UHB, there is a lack of continuous, robust monitoring. This would require the reestablishment of a digital climate change program dashboard, setting of qualitative and quantitative KPIs aligned with targets, and a seamless data collection process for all decarbonisation actions. Sustainability needs to be embedded in decision-making. The business plan template needs to capture sustainability from decarbonisation and climate risk perspectives and should be given appropriate weight. Climate Impacts	A working group or delivery group needs to be established, comprising staff who are owners of decarbonisation actions, to highlight progress and barriers.

Strategic Risks – Sustainability

Given the nascent stage of climate adaptation in UHB, it needs more resources to be properly explored and established. As climate risk exacerbates all existing risks, it ultimately strains UHB's finances in the future if not acted upon appropriately now. Climate Impacts needs to be included in appropriate risk registries, and risk thresholds needs to be set.	

Risk Post-Controls and Mitigation			
Impact: 4	Likelihood: 5	Net Risk: 20	

Actions

What	Lead	By	Update
The 25/26 Quality Improvement and Efficiency Plan has been developed as part of the 2025-26 financial plan	Catherine Phillips/ Paul Bostock	Ongoing during 2025-26 Financial Year	SLT will continue to monitor the 'go further options' for the UHB. Each Clinical Board will present to SLT for 30 minutes each month on how they have progressed toward their 2025-26 QIEP targets following rapid planning events in December 2024 and April 2025. A monitoring function for all plan aspects has been developed and is being utilised in the Finance & Performance Committees during 2025-26. The monitoring reports also support all other fora in which the QIEP delivery is being discussed and supported.
The emission gap between the health board's current emission pathway and targets set by the Welsh government and the SOFW strategy is widening. Hence, the emission reduction targets, and pathway need to be reviewed.	Catherine Phillips	September 2025	A Sustainability Program Board has been established to review and monitor progress of decarbonisation actions.

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Sustainability and Climate Response

Ruth Jordan
Asst Dir – Improvement, Implementation and

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Overview:

The world is on track to breach the 1.5 °C global warming pathway, underscoring the urgent need to decarbonise healthcare operations and build climate resilience into our infrastructure and services. Cardiff and Vale University Health Board (CAVUHB) is committed to creating a system and culture of sustainability that delivers healthcare services which are environmentally responsible, equitable, timely, and safe.

The Sustainability and Climate Response Program focuses 2 overarching themes:

- Decarbonising operations across all clinical and non-clinical areas by reducing our carbon footprint.
- Embedding climate resilience to safeguard staff and patient care during extreme weather and climate-related events.





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Targets:

Our targets are governed by sustainability outcomes set by Welsh Government under Decarbonisation-Strategic Delivery Plan, and the Shaping Our Future Wellbeing Strategy:

- Reduce total emissions by **16% by 2025** and **34% by 2030** (2018/19 baseline c160,000 tonnes CO2).
- Cut emissions we directly control by **40% by 2027** and **68% by 2035**.
- **Undertake Climate Risk Assessment** and **design a Climate Adaptation Plan** to ensure resilience across healthcare operations.

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Carbon Emissions Scenario:

Despite ongoing efforts to decarbonise operations, Cardiff and Vale University Health Board (CAV UHB) reported **260,091.87 tonnes of CO_2** (tCO_2) in 2024–25 a **62.5%** increase from the 2018/19 baseline of **160,000 tCO_2**. This also represents a significant rise of **79,966.02 tCO_2 (44.39%)** compared to the previous year, making CAV UHB the largest carbon footprint holder in NHS Wales.

Emissions in 2024-25 rose across:

- **Scope 1** – Direct emissions (direct control), from owned or controlled sources (e.g., heating, fleet).
- **Scope 2** – Indirect emissions (direct control), from purchased energy.
- **Scope 3** – Other indirect emissions (indirect control), including supply chain and procurement.

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Total Emissions (tCO_2):

Emission Scope	2023-24	2024-25	Change in Emission
Scope 1	26,366.16	28,465.00	**+2,098.84**
Scope 2	2,975.08	5,613.62	**+2,638.54**
Scope 3	150,784.60	226,013.01	**+75,228.41**
Total	180,125.85	260,091.87	**+79,966.02**

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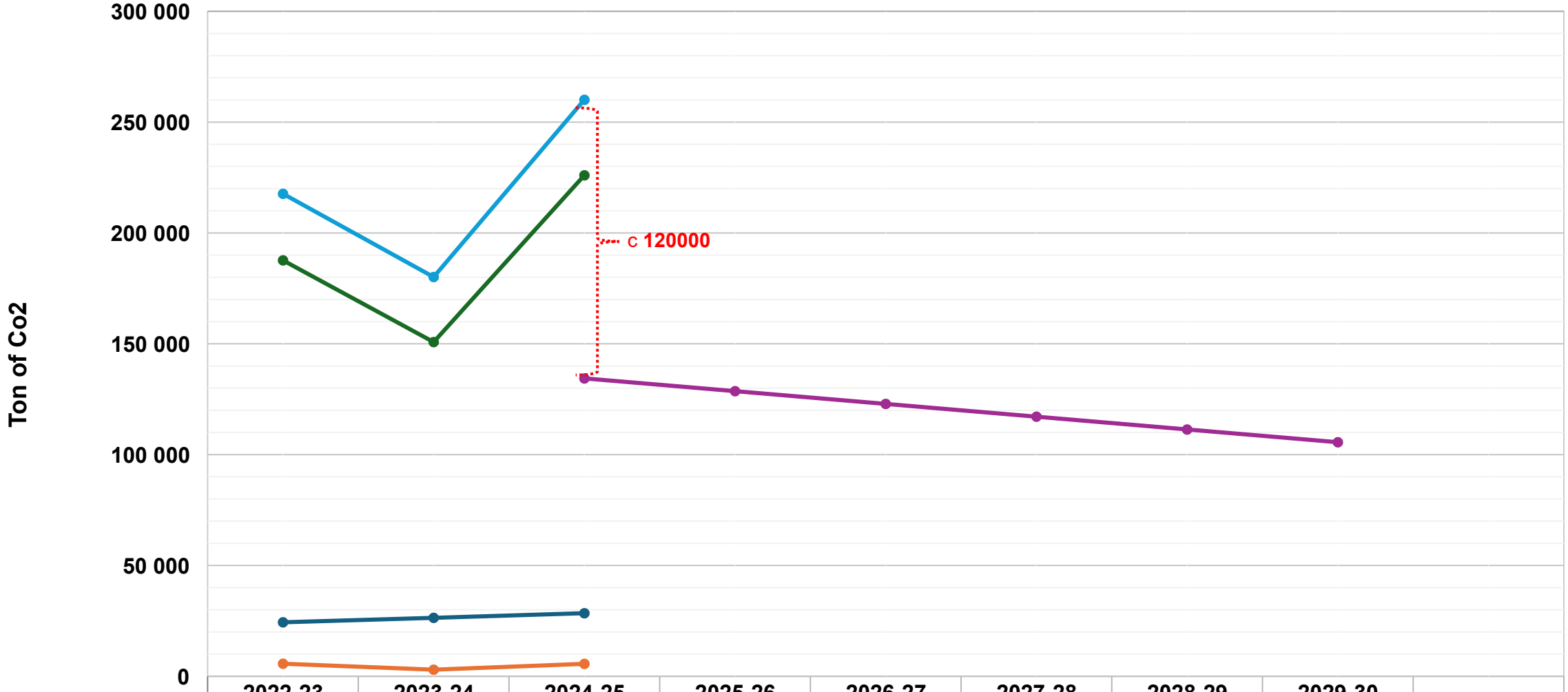
CAVUHB Emission Scenario



	2022-23	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29	2029-30
Scope 1	24 360	26 366	28 465					
Scope 2	5 676	2 975	5 614					
Scope 3	187 655	150 785	226 013					
Total	217 691	180 126	260 092					
Emission Reduction pathway			134 400	128 640	122 880	117 120	111 360	105 600

Scope 1 Scope 2 Scope 3 Total Emission Reduction pathway Linear(Emission Reduction pathway)

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Climate Impact Scenario :

- CAV UHB is in the initial stages of conducting its Climate Change Risk Assessment (CCRA), which will inform the Climate Adaptation Plan, and has already highlighted significant climate-related impacts on healthcare delivery.

- As part of this work, the Heatwave Staff Impact Survey captured 880 responses, revealing critical vulnerabilities across the organisation. Findings show that heatwaves are destabilising services, assets, workforce wellbeing, and patient safety, while amplifying existing risks and creating new ones, all with significant short- and long-term financial implications for CAV UHB.

- Initial climate data analysis shows increasing intensity and frequency of heatwaves, flooding, and other extreme events in Cardiff and Vale of Glamorgan region this will place enhanced demand for health care needs on CAV UHB.

Overarching Risks :

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Strategic Risks:

CAV UHB is not in line of sight of achieving neither Welsh Government targets nor targets set by Shaping Our Future Wellbeing Strategy as our emissions are increasing.

Operational & Financial Risks:

Recent heatwave survey, which received 880 responses, showed that CAV UHB faced system-wide impacts, with 80% of staff experiencing high discomfort and 32% reporting health effects. Additionally, 30% of clinicians observed increased **patient footfall and increased length of stay** during heatwaves. Combined with climate projections of more frequent and intense events, these trends pose significant operational challenges and financial strain, underscoring the urgent need for workforce protection and resilient care environments.

Legal Risks:

Across the UK, public sector organisations and local authorities are increasingly facing legal action for failing to take sufficient steps to meet their emission reduction targets and to adapt to the changing climate. CAV UHB's current trajectory of not meeting its emission reduction targets and showing slow progress on climate adaptation could expose the organisation to climate litigation risks.

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Governance and Assurance:

The Sustainability and Climate Response Program Board has been established to deliver across five key areas:

1. Localisation of NHS Wales Decarbonisation-Strategic Delivery Plan
2. Climate Risk Assessment & Adaptation plan
3. CAV UHB Climate Response Plan
4. Clinical Boards' Sustainability Enablement
5. Welsh Government Reporting & Compliance





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SLT/Future Generation Portfolio

Sustainability and Climate Response Program Board

CAV Green Group	Clinical Sustainability Leads Working Group (TBE)	Sustainability and Climate Response Delivery Group	Climate Adaptation – Task and Finish Group
The Green Group acts as a platform for motivated admin and clinical staff across the health board to discuss and share sustainable ideas. The group will act as one of the structures that bring about sustainable behavioral change.	The Clinical Sustainability Leads Working Group focuses on integrating sustainable practices within clinical settings and act as a strategic vehicle to design and deliver sustainability initiatives in clinical setting. The members will consist of Sustainability leads from each Clinical Board	The Sustainability and Climate Response Delivery Group is responsible for delivering, UHB's Decarbonisation Actions and Climate Adaptation Actions. The members will consist of Decarbonisation and Climate Adaptation action owners.	Climate Adaptation - Task and Finish Group will undertake a high-level climate change risk assessment for C&V UHB. Following which it will develop an adaptation action plan to address the risks identified, prioritising those with most significant impact which currently have no or insufficient mitigation in place.

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Gaps and Challenges :

- CAV UHB has limited resources to deliver Sustainability and Climate response; this has been a big strain on embedding sustainability and building climate response.
- There is a clear upward trend in healthcare demand at CAV UHB, which is driving increased resource use and ultimately increasing the carbon footprint.
- Carbon lock in and poor embedding on sustainability in current care delivery/pathways.
- Given the nascent understanding of climate change impacts on CAV UHB, the organisation currently has limited adaptive capacity. Building this capacity among senior leaders and key internal stakeholders is keystone to achieving climate resilience. However, competing priorities mean there is currently no clear pathway to realise this.

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Emerging Priorities and Work streams:

- Develop an overarching Climate Response Plan to integrate decarbonisation efforts and build climate resilience across Cardiff and Vale UHB.
- Embedding sustainability and climate response across the UHB, by including it in IMTPs, Clinical Services Plan and other relevant plans .
- To assess and enhance the understanding of climate risks and design a robust Climate Adaptation Plan tailored to the UHB's operational and patient care needs.
- Conduct Climate Change Adaptation workshops to SLT and key internal stakeholders to enhance adaptive capacity.
- Identify resource requirements necessary to deliver the Sustainability and Climate Response Programme effectively.

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Thank You

Report Title:	Monthly Monitoring Return – Month 6			Agenda Item no.		4.1
Meeting:	Finance and Performance Committee		Public	x	Meeting Date:	19th November 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 September 2025/26 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:

4.1b Financial Monitoring Returns Month 6 2025/26

4.1c 2024-25 MMR Template - Cardiff Vale UHB Month 6

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/

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.**	

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

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

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: No

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Finance and Performance Committee	Date: 19th November 2025

THE WELSH GOVERNMENT FINANCIAL COMMENTARY

FINANCIAL POSITION FOR THE SIX MONTH PERIOD ENDED 30th SEPTEMBER 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 is 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 30th September 2025.

A full commentary has been provided to cover the tables requested for the month 6 financial position.

At month 6 the UHB is reporting an overspend of £31.843m, £3.727m off plan. The month 6 position represents an in-month improvement of £0.652m reported against the £4.379m overspend against plan reported at month 5. The position at month 6 is supported by the release of a £1.032m Provision for Fire Case at Hafen Y Coed.

The Overspend of £31.843m is comprised of £4.035m of operational deficit and the planned deficit of £28.116m (6 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) offset by a (£0.308m) surplus against savings.

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 6 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.
- Assumed LTA inflation of £2.471m (1.77%) 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 £2.145m.
- The potential further Risk Pool liability of £9.284m as follows:
  - Medium Risk - £7.378m arising from the indicative apportionments of the £41.964m increased risk above IMTP Planning forecasts.
  - Low Risk - £1.906m arising from the indicative apportionments of the £11.370m further increased risk above IMTP Planning forecasts.
- The potential additional cost of band 2 & 3 pay costs is currently estimated at £8.310m in 2025/26.
- The potential opportunity arising from the Microsoft DHCW Review has been removed.

ACTUAL YEAR TO DATE (TABLE B AND B2)

Table B confirms the year to date deficit of £31.843m and reflects the analysis contained in the annual operating plan in Table A. The deficit of £31.843m for the year to date as shown in Table 2.

Table 2: Summary Financial Position for the period ended 31st September 2025

	Plan PTD (£m)	PTD (£m)	PTD Variance to Plan (£m)	Plan YTD (£m)	YTD (£m)	YTD Variance to Plan (£m)
Draft Plan	6,563	5,807	(756)	41,579	41,579	0
Quality Efficiency Improvement Plans - Savings	(1,876)	(3,650)	(1,774)	(13,463)	(13,771)	(308)
Operational Variance	0	1,121	1,121	0	4,034	4,034
Clinical/Service Board Variance	**4,686**	**3,278**	**(1,409)**	**28,116**	**31,843**	**3,727**

The month 6 deficit of £31.843m comprised of the following:

- £28.116m planned deficit
- (£0.308m) CRP surplus
- £4.034m adverse operational variance against plan.

The £56.2m forecast deficit is profiled flat.

It is anticipated that the operational pressures reported at month 6 will be recovered and mitigated as the year progresses and that the UHB will deliver its planned deficit position of £56.233m.

A number of operational pressures have continued into month 6, alongside non recurrent pressures around the GP out of hours pay resolution and resident doctors banding. The pressures are partly offset by operational underspends across service areas as summarized below:

Table 3: Operational Pressures for the period ended 31st September 2025

Operational Pressure	Operational Variance YTD £'000s	Operational Variance Forecast £'000s
Mental Health Out Of Area Placements (OOA)	1,500	2,063
Specialist Services Activity Related Underperformance	1,900	0
Employers NI (ENIC) Funding Gap	1,073	2,145
JCC Forecast Outurn Growth	600	600
GP Out of Hours pay resolution	1,000	1,000
Pay Vacancies & other mitigating actions to be agreed	(2,039)	(5,808)
Sub-Total Surplus/Deficit	**4,034**	**0**

Further detail in relation to table 3 is provided below:

- Mental Health OOA - There was average of 9 additional patients against plan in month 6. Furthermore, the cost of packages is higher than planned due to the acuity of patients. The UHB is working to improve the condition of the estate which houses the Crisis Service to increase internal capacity to manage the flow of patients into OOA placements as well as exploring a number of further options to reduce the volume and cost of OOA.
- Specialist services underperformance. There is reported underperformance in cardiac services where the UHB is reviewing activity flows. Underperformance against out of area critical care capacity has increased in month as the proportion of beddays occupied by Cardiff & Vale patients is higher than observed in previous years.
- The Employers NI Gap is the difference between confirmed funding and the allocation to delegated budgets.
- Commissioning. The risk against the JCC forecast outturn is abated by the reduction in the forecast cost of Velindre drugs and recognized at £0.600m for the year to date.

- The additional £1.0m GP OOHs pay resolution cost relates to back pay based on most recent BMA guidance and draft worker terms. Updated guidance is being worked through.
- Pay vacancies along with enhanced scrutiny around variable pay partially offset pressures against medical staff where additional costs are being incurred to cover vacancies, Less Than Full Time (LTFT) posts and sickness.

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)

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.

Following confirmation of the month 5 position, the UHB undertook deep dives for all clinical boards to understand the issues and risks and gain assurance on the actions required to deliver within their deficit control totals. Further measures were approved to arrest and recover the financial run rate and the UHB's saving tracker is now reporting a £0.617m surplus of green and amber schemes against the £32m in year target.

As previously outlined, the following additional actions have been identified to halt and recover the deteriorating operational position across all delegated budgets:

- 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, which the UHB 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)

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 programme funding, additional planned care funding, the impact of the Real Living Wage increase on the cost of UHB employees at bands 2 & 3 and the Pay awards actioned in August 2025.

Table 4 – Additional Resource Limit adjustments since initial plan (Confirmed and Anticipated)

Additional Resource Limit Allocations	£'000s
25_26 NIER Additional 1.2 Percent And Threshold Change	16,697
All Wales International Recruitment	7
AME Non Cash Depreciation - IFRS 16 Leases (Peppercorn)	77
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) Investment Facility	564
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	253
Decabonisation Secondment	28
DEL Non Cash Depreciation - Accelerated	1,979
DEL Non Cash Depreciation - Baseline Surplus / Shortfall	(3,376)
DEL Non Cash Depreciation - IFRS 16 Leases	2,912
Dementia Action Plan	100
DoLS / MCA / Advocacy (MH)	64
DPIF	3,777
ESMCP Control Room	116
ESMCP Wast Resources	38
Climate-Focussed Spread And Scale Academy	52
Genomics (C&V / JCC)	323
Individual Placement & Support In Primary Care	440
Immunisation Allocation 25/26 MPOX	18
Invest To Save - Welsh Government Energy Service	(347)
Learning Disability Policy _Additional Funding 2025_26	(4)
MOD St Athan Funding Lazurite Team Additional Reception Site For EPS	(281)
Neighbourhood District Nursing	137
Neurodivergence Improvement Programme	158
New Medical Training Posts 2017 to 2024	283
Pay award funding 2024-25	(4,298)
Pay award funding 2024-25 funded through Pay Matrix Commisioning Shares	(10,519)
PCIC_MTHS 1-12_SHORT BREAKS FOR CARERS	172
Planned Care Additional Funding 2025-26 - Phase 3 Outpatients	193
Planned Care Transformation Fund	671
Planned Care National Outpatient Plan Minor Oral Surgery	240
Planned Care Transformation Fund_ High Volume Mega Clinics	28
Planned Care Insourcing	3,100
Prevention and Early Years	43
Real Living Wage (RLW) Social Care	(2,513)
Real Living Wage Rlw 2025_26	3,344
Removal of Donated Assets / Government Grant Receipts	(521)
Removal of IFRS-16 Leases (Revenue)	(744)
RSV Vaccination Programme	246
RSV At Risk Neo Nate Vaccine Programme	45
RTt Waiting Times _ Q1 Plans	3,011
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
VT LTA Adjustment -Historic Pay Award 2025-26	110
Wast Mobile Data Vehicle Solutions	108
Women's Health - Pathfinder Establishment (Women's Health Hubs)	300
Pay Award 2025_26 Post RLW	34,968
JCC_25_26 English Tariff Cuf	(110)
GMS Global Sum/Psp List Size Adjustment	210
Total Movement in assumed Resource Limit following MDS Submission £'000s	**83,238**

PAY & AGENCY (TABLE B2)

The UHB recorded Agency costs of £0.500m in month.

Agency Costs have reduced from an monthly average of £0.507m in 2024/25 to £0.405m in 2025/26 as a result of enabling actions taken to manage down UHB agency usage.

The UHB recorded expenditure on A&C, ACS and Estates categories September as follows:

- Administrative, Clerical & Board Members - £0.004m – vacancy cover Clinical coders
- Additional Clinical Services - £0.047m – specialing cover for high acuity patient
- Estate & Ancillary - £0.012m – vacancy cover

Savings Programme 2025-26 (TABLE C, C1, C2, C3 & C4)

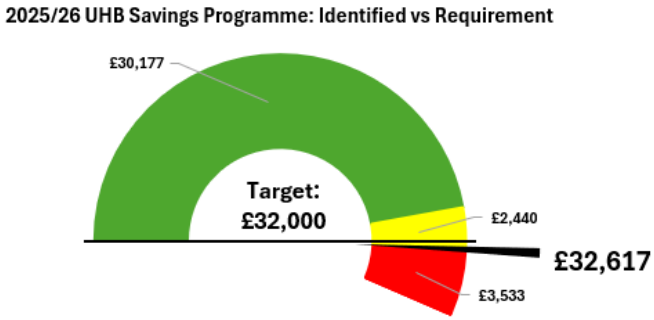
The UHB acknowledges that a deadline of the 11 September 2025 (Month 5 MMR submission date) was assigned to the Health Board to finalise the 'Planned Savings' gap and that all schemes should meet the 'Green' criteria by that date.

The forecast delivery against amber and green schemes increased from £28.482m at month 5 to £ 32.617m at the end of month 6, which is 101.9% of the £32m savings target. £30.177m of the schemes were rated Green with a further £2.440m amber schemes. In the light of this, the UHB has strong assurance that it will meet the £32m planned savings target in 2025/26. **Further action is required to meet the recurrent target** and the UHB continues to press all parts of the organisation to agree urgent actions that will accelerate savings to mitigate ongoing risks on a recurrent basis.

Red schemes of £3.533m were identified and continue to be reviewed for progression to Green/Amber where possible.

There is a reported surplus of £0.617m against the £32.0m savings target and this is expected to mitigate ongoing operational pressures. 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



Welsh Government MMR rules require amber schemes which have not moved to green status within a 3 month window to be removed from the Table C3 tracker. £1.226m of amber screens which are categorised as amber on the UHB tracker which are still deemed to be deliverable in year have breached this rule. To ensure consistency in the overall reporting of amber and green schemes between the UHB tracker and MMR, £1.226m of amber schemes (48 schemes) which have breached the 3 month rule have been included and reported on the Table C3 tracker. The UHB is confident that the majority of these schemes will deliver in year and will be reviewing the schemes with budget holders to ensure that schemes are re-categorised from amber to green in future months, where there is strong assurance that schemes will release savings in year.

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 concluded and signed all Long Term Agreements (LTA) and Service Level Agreements with other Welsh NHS LHBs for 2025-26.

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 assumes that Welsh Government will continue to authorise the accounts adjustment of £0.222m recognised in previous financial years.

The UHBs confirmed Revenue Resource Limit as of September 30th, 2025, was £1,427m with a further £84.9m of assumed allocations as detailed at Table 5 below:

Table 5 – Unconfirmed in year Resource Limit Allocations anticipated on 31st September 2025

Unconfirmed Resource Limit Allocations as of 30th September 2025	£'000s
Depreciation, Impairments & IFRS 12	33,744
Pay award funding 2025-26 (non RLW)	34,968
Pay Award Funding Real Living Wage RLW 2025_26 - Additional Employer Costs	3,344
Vertex (JCC)	5,230
Planned Care Insourcing	3,100
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
Neurodivergence Improvement Programme	793
AWTCC Voluntary Scheme For Branded Medicines Pricing, Access And Growth (VPAG) Investment	564
Dols / MCA / Advocacy (MH)	233
Planned Care Transformation Fund	593
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	1,405
Total Anticipated Funding £'000s	**88,005**

The level of unconfirmed allocation (£88.0m less the £33.7m depreciation funding) will present a cash management risk (£54.3m) to the UHB if it remains outstanding into the Autumn period.

MONTHLY CASHFLOW FORECAST (TABLE G)

The closing cash balance at the end of August, was £3.667m.

The outstanding confirmation of cash allocations is a cause for concern for the UHB alongside the strategic and working cash requirement. Table 6 summarises the potential for a £127.5m cash shortfall at year end before outstanding cash allocations and strategic support are confirmed by Welsh Government.

Table 6 – Summary of Potential Cash Shortfall at Year End

Summary of Potential Cash Shortfall at Year End	£'000s
Outstanding allocations	54,261
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
Band 2/3 back pay and Welsh Risk Pool Risks (potential £17.594m)	tbc
Total £'000s	**127,494**

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 £17m of working cash support to cover 2024/25 revenue and capital working balances in April 2025.

The UHB will continue to review the movement in its working balances cash for Capital and Revenue as the year progresses. Revisions to the estimate of any associated cash support required will be included in table E.

The risk associated with cash increases when it is combined with the forecast financial deficit (£56.2m); the band 2/3 pay arrears risk , the potential additional Welsh Risk Pool contribution; and the requirement of the UHB to fund multi-million pound clinical negligence settlements instructed by the Welsh Risk Pool (WRP) where 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 small decrease in the carrying values of Trade and Other receivables is predominantly due to movements within the WRP values. The movement in amounts disclosed as Current and Non-Current is the result of a number of WRP cases being reclassified as Non-Current.

The carrying value of Trade and Other Payables has remained constant. The split of Provisions reflects a reclassification of the timing.

The forecast balance sheet reflects the University Health Board's latest non-cash estimates and anticipated capital funding.

It also accounts for the 2024/25 capital programme being heavily weighted towards Month 12, resulting in a high level of capital creditors carried forward into 2025/26. In response to an audit risk query, efforts are underway to complete capital works earlier in the financial year, with a forecast reduction in capital creditor levels (c.£10m). Movements in other accruals—totaling around £6 million across various areas of the UHB, have also been incorporated. Additionally, the successful resolution of an ongoing claim has enabled the forecasted release of a £1 million provision. These Statement of Financial Position (SoFP) changes are reflected in the accompanying cash working capital requirements 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 September was 96.2%.

CAPITAL RESOURCE LIMIT, IN YEAR SCHEMES & DISPOSALS (TABLES I, J, K & Q)

Of the UHB's approved Capital Resource Limit, 14% has been expended to date.

Following the month 6 scheme slippage review two schemes have been identified as medium risk with the lift refurbishment scheme forecasting slippage of £1.313m and Pentyrch Branch Surgery £0.780m. All other schemes are expected to deliver in line with forecast.

Planned expenditure for the year reflects the CRL received from Welsh Government dated 6th October 2025 - £37.664m.

The month 6 return includes a one-off VAT recovery for various capital projects, and this is reflected in the negative figures against some schemes.

AGED WELSH NHS DEBTORS (TABLE M)

On the 30th of September 2025 there were no invoices raised by the UHB against other Welsh NHS organisations which were outstanding for more than 17 weeks. Both invoices have now been paid.

GMS & DENTAL (TABLES N & O)

GMS and Dental expenditure at quarter 2 are reported on tables N & O.

RINGFENCED ALLOCATIONS (TABLE P)

Expenditure against Ringfenced Allocations is forecast in line with allocations.

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 £31.843m and the forecast deficit of £56.2m.
- the month 6 operational overspend against plan is £4.035m and in addition there is year to date surplus of (£0.308m) against the savings target.
- £32.617m (101.9%) of green and amber schemes are identified at Month 6 against the £32m target.
- Delivery of the forecast is also predicated on the confirmation of all expected income streams.
- There is a potential £127.5m cash shortfall at year end before outstanding cash allocations and strategic support are confirmed by Welsh Government.

……..
SUZANNE RANKIN
CHIEF EXECUTIVE

13th October 2025

……..
CATHERINE PHILLIPS
EXECUTIVE DIRECTOR OF FINANCE

13th October 2025

Cardiff & Vale ULHB **Period : Sep 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	485	671	-185	55
16	Other Movement in Month 1 Planned Savings - (Underachievement) / Overachievement	-4,134	-246	-3,888	-4,561
17	Additional In Year Identified Savings - Forecast	10,386	5,366	5,020	6,079
18	Variance to Planned RRL	-1	-1		
19	Additional In Year & Movement in Planned Welsh Government Funding & Other Income (Positive Value - additional)	-6,255	-6,255	0	0
20	In Year Accountancy Gains	1,632	1,632	0	0
21	Unplanned Spend Reductions	9,664	9,399	265	265
22	Unplanned Cost Pressures	-7,753	-7,753	0	0
23	Planned Mitigations Yet To Be Finalised	0	0	0	0
24	Unplanned Additional Required Mitigations Yet To Be Finalised	3,727	3,727	0	7,120
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**	**14,230**	**-70,464**	**-56,233**

		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	-29,950	-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	-25,550	-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	10,149	20,297
4		206	206	206	206	206	206	206	206	206	206	206	206	1,236	2,471
5		1,432	853	391	14	135	39	-396	-266	-367	-435	-422	-977	2,864	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	8,709	22,185
7		54	71	133	190	175	190	201	216	201	216	201	216	813	2,063
8														0	0
9														0	0
10														0	0
11			523	1,023	689	689	689	689	689	689	689	689	689	3,614	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**	**-28,117**	**-56,233**
13		0	-523	-1,023	-689	-689	-689	-689	-689	-689	-689	-689	-689	-3,614	-7,751
14														0	0
15		0	8	4	115	-26	80	-38	-38	-31	4	4	405	182	485
16		0	0	-204	-808	-392	-165	-362	-463	-446	-506	-464	-323	-1,569	-4,134
17		0	259	650	1,609	704	803	1,012	1,000	1,000	1,027	1,025	1,298	4,024	10,386
18				-489	-1,012	726	395	142	254	230	228	189	-663	-380	-1
19		2,589	3,002	-7,155	-521	-521	-521	-521	-521	-521	-521	-521	-521	-3,127	-6,255
20		0	0	474	126	0	1,032	0	0	0	0	0	0	1,632	1,632
21		189	3,015	296	804	521	1,446	565	565	566	565	565	565	6,272	9,664
22		0	-2,133	-117	-894	-2,273	-1,727	-108	-108	-108	-108	-108	-72	-7,144	-7,753
23		0	523	-523	0	0	0	0	0	0	0	0	0	0	0
24		0	0	0	0	0	0	621	621	621	621	621	621	0	3,727
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**	**-6,637**	**-4,034**	**-4,065**	**-4,065**	**-4,065**	**-4,065**	**-4,065**	**-4,066**	**-31,842**	**-56,233**

Cardiff & Vale ULHB

Period : Sep 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	3,714	10,103		0	1,191			
2		Actual/F'cast	379	556	814	799	1,065	949	1,063	1,038	1,254	1,254	1,294	1,309	4,562	11,772	38.75%	10,485	1,287	4,343	7,429	11,805
3		Variance	0	76	237	161	238	137	172	145	132	93	132	146	848	1,669	*22.84%*	10,485	96			
4	Non-Pay	Budget/Plan	437	342	558	766	471	514	795	648	535	535	535	1,075	3,088	7,211		6,566	645			
5		Actual/F'cast	437	506	806	977	544	722	1,004	768	685	679	679	1,605	3,991	9,411	42.41%	9,075	336	5,775	3,635	4,464
6		Variance	0	164	247	211	72	208	210	120	150	144	144	530	903	2,199	*29.22%*	2,509	-310			
7	Primary Care - Drugs & Appliances	Budget/Plan	73	73	73	87	87	87	97	97	97	111	111	111	481	1,107		1,005	102			
8		Actual/F'cast	73	73	73	687	87	175	403	403	403	431	431	431	1,168	3,671	31.83%	3,563	108	661	3,010	3,207
9		Variance	0	0	0	600	0	88	306	306	306	319	319	319	688	2,565	*143.16%*	2,559	6			
10	Secondary Care Drugs	Budget/Plan	49	82	85	85	85	85	87	87	87	87	87	87	471	992		982	10			
11		Actual/F'cast	49	100	103	108	190	176	187	191	191	191	191	205	725	1,882	38.55%	1,858	24	441	1,440	1,480
12		Variance	0	18	18	23	105	90	100	104	104	104	104	118	254	889	*53.95%*	875	14			
13	CHC/FNC	Budget/Plan	59	59	142	170	170	220	273	273	273	273	273	273	820	2,458		1,938	520			
14		Actual/F'cast	59	59	86	(23)	66	334	126	126	126	126	126	126	582	1,336	43.54%	1,206	130	1,120	216	1,126
15		Variance	0	0	(56)	(192)	(104)	114	(147)	(147)	(147)	(147)	(147)	(147)	(238)	(1,122)	*(29.02%)*	-732	-390			
16	Primary Care Contractor	Budget/Plan	0	0	0	9	10	12	12	12	12	12	12	12	30	103		103	0			
17		Actual/F'cast	0	0	0	9	10	12	21	21	21	21	21	21	30	155	19.67%	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	15	30		30	0			
20		Actual/F'cast	3	3	3	3	3	3	3	3	3	3	3	3	15	30	50.00%	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	90	180		180	0			
26		Actual/F'cast	15	15	15	15	15	15	15	15	15	15	15	15	90	180	50.00%	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	8,709	22,185		10,804	0			
35		Actual/F'cast	1,014	1,311	1,899	2,575	1,979	2,385	2,822	2,564	2,697	2,718	2,758	3,713	11,164	28,436	50.00%	26,552	1,885	12,393	16,044	22,409
36		Variance	0	258	446	802	312	637	650	537	554	521	560	975	2,455	6,252	*0.00%*	15,748	1,885			

37	Variance in month	0.00%	24.52%	30.69%	45.21%	18.70%	36.46%	29.92%	26.48%	25.83%	23.73%	25.49%	35.61%	28.19%	
38	In month achievement against FY forecast	3.57%	4.61%	6.68%	9.05%	6.96%	8.39%	9.92%	9.02%	9.49%	9.56%	9.70%	13.06%		

Regan, Nikki
18/11/2025 15:48:55

Cardiff & Vale ULHB **Period : Sep 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	314	347	427	488	677	662	740	742	972	1,011	1,012	1,012	2,915	8,403	0	1,191			
2	Pay - General & Substantive	Actual/F'cast	314	422	668	674	937	811	824	799	1,015	1,014	1,055	1,070	3,827	9,603	8,836	767	2,428	7,175	11,338
3		Variance	0	76	241	186	261	149	83	56	44	4	43	58	912	1,200	8836.071747	(424)			
4		Budget/Plan	32	100	117	117	117	117	117	117	117	117	117	117	599	1,300	0	0			
5	Pay - Variable	Actual/F'cast	32	100	112	92	94	105	206	206	206	206	206	206	534	1,769	1,249	520	1,515	254	467
6		Variance	0	0	(4)	(25)	(23)	(12)	89	89	89	89	89	89	(64)	469	1,249	520			
7		Budget/Plan	33	33	33	33	33	33	33	33	33	33	33	33	200	400	0	0			
8	Pay - Agency	Actual/F'cast	33	33	33	33	33	33	33	33	33	33	33	33	200	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	3,714	10,103	0	1,191			
11	Total	Actual/F'cast	379	556	814	799	1,065	949	1,063	1,038	1,254	1,254	1,294	1,309	4,562	11,772	10,485	1,287	4,343	7,429	11,805
12		Variance	0	76	237	161	238	137	172	145	132	93	132	146	848	1,669	10,485	96			

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	3,714	10,103
2	Workforce	Actual/F'cast	379	556	814	799	1,065	949	1,063	1,038	1,254	1,254	1,294	1,309	4,562	11,772
3		Variance	0	76	237	161	238	137	172	145	132	93	132	146	848	1,669
4		Budget/Plan	122	134	138	153	153	153	164	164	164	178	178	178	853	1,881
5	Medicines Management	Actual/F'cast	122	153	156	782	264	337	588	592	592	619	619	633	1,814	5,458
6		Variance	0	18	18	629	111	185	424	428	428	441	441	455	962	3,577
7		Budget/Plan	454	379	571	778	484	527	807	660	547	547	547	1,087	3,193	7,389
8	Procurement & Non-pay	Actual/F'cast	454	544	793	974	541	719	991	755	671	665	665	1,591	4,026	9,365
9		Variance	0	164	222	196	57	193	184	95	124	118	118	504	833	1,976
10		Budget/Plan	59	59	142	170	170	220	273	273	273	273	273	273	820	2,458
11	CHC	Actual/F'cast	59	59	86	(23)	66	334	126	126	126	126	126	126	582	1,336
12		Variance	0	0	(56)	(192)	(104)	114	(147)	(147)	(147)	(147)	(147)	(147)	(238)	(1,122)
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	100	250
17	Other - Commissioning	Actual/F'cast	0	0	50	33	33	33	33	33	33	33	33	33	150	350
18		Variance	0	0	25	8	8	8	8	8	8	8	8	8	50	100
19		Budget/Plan	0	0	0	9	10	12	12	12	12	12	12	12	30	103
20	Other - Primary Care	Actual/F'cast	0	0	0	9	10	12	21	21	21	21	21	21	30	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	8,709	22,185
23	Total	Actual/F'cast	1,014	1,311	1,899	2,575	1,979	2,385	2,822	2,564	2,697	2,718	2,758	3,713	11,164	28,436
24		Variance	0	258	446	802	312	637	650	537	554	521	560	975	2,455	6,252

Cardiff & Vale ULHB

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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	8,709	22,185	7,272	14,912	5,979	20,891
	Month 1 - Actual/Forecast	1,014	1,052	1,250	965	1,275	1,582	1,810	1,565	1,697	1,691	1,734	2,415	7,139	18,050	7,026	11,024	5,306	16,330
	Variance	0	(0)	(204)	(808)	(392)	(165)	(362)	(463)	(446)	(506)	(464)	(323)	(1,569)	(4,134)	(246)	(3,888)	(673)	(4,561)
	In Year - Plan	539	444	839	1,490	720	876	1,090	1,063	1,073	1,136	1,008	1,247	4,910	11,526	5,607	5,919	3,439	9,358
	In Year - Actual/Forecast	0	259	650	1,609	704	803	1,012	1,000	1,000	1,027	1,025	1,298	4,024	10,386	5,366	5,020	1,059	6,079
	Variance	(539)	(186)	(190)	120	(16)	(74)	(78)	(63)	(73)	(109)	17	52	(885)	(1,140)	(241)	(899)	(2,380)	(3,279)
	Total Plan	1,554	1,497	2,292	3,263	2,388	2,624	3,262	3,090	3,216	3,333	3,206	3,985	13,618	33,711	12,879	20,831	9,418	30,249
	Total Actual/Forecast	1,014	1,311	1,899	2,575	1,979	2,385	2,822	2,564	2,697	2,718	2,758	3,713	11,164	28,436	12,393	16,044	6,365	22,409
	Total Variance	(539)	(186)	(393)	(688)	(409)	(239)	(440)	(526)	(519)	(615)	(448)	(272)	(2,455)	(5,274)	(487)	(4,787)	(3,053)	(7,840)
Net Income Generation	Month 1 - Plan	54	71	133	190	175	190	201	216	201	216	201	216	813	2,063	418	1,645	505	2,150
	Month 1 - Actual/Forecast	54	71	83	72	109	128	125	140	125	175	160	205	517	1,447	385	1,063	627	1,690
	Variance	0	0	(50)	(118)	(66)	(62)	(76)	(76)	(76)	(41)	(41)	(11)	(296)	(616)	(33)	(582)	122	(460)
	In Year - Plan	102	110	64	133	40	142	37	37	45	241	39	213	590	1,203	806	397	119	516
	In Year - Actual/Forecast	0	8	54	233	40	142	37	37	45	45	45	415	477	1,101	704	397	118	515
	Variance	(102)	(102)	(10)	100	(0)	0	0	0	0	(197)	6	202	(112)	(101)	(101)	(0)	(1)	(1)
	Total Plan	155	181	198	323	215	332	238	253	245	457	240	429	1,403	3,266	1,224	2,042	624	2,666
	Total Actual/Forecast	54	79	138	305	149	270	162	177	170	220	205	620	994	2,548	1,089	1,460	745	2,205
	Total Variance	(102)	(102)	(60)	(18)	(66)	(62)	(76)	(76)	(76)	(238)	(35)	191	(408)	(717)	(135)	(582)	121	(461)
Accountancy Gains	In Year - Plan	0	0	474	0	0	1,032	0	0	0	0	0	0	1,506	1,506	1,506	0	0	0
	In Year - Actual/Forecast	0	0	474	126	0	1,032	0	0	0	0	0	0	1,632	1,632	1,632	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	9,522	24,248	7,690	16,557	6,484	23,041
	Month 1 - Actual/Forecast	1,068	1,123	1,333	1,037	1,384	1,711	1,935	1,705	1,822	1,866	1,894	2,620	7,656	19,498	7,411	12,087	5,934	18,020
	Variance	0	(0)	(254)	(926)	(458)	(227)	(438)	(539)	(522)	(547)	(505)	(334)	(1,865)	(4,750)	(279)	(4,470)	(550)	(5,021)
	In Year - Plan	641	554	1,378	1,622	760	2,050	1,127	1,100	1,117	1,377	1,047	1,460	7,005	14,235	7,919	6,316	3,558	9,874
	In Year - Actual/Forecast	0	267	1,178	1,969	744	1,976	1,049	1,037	1,045	1,072	1,069	1,714	6,134	13,119	7,702	5,417	1,177	6,594
	Variance	(641)	(287)	(200)	346	(16)	(74)	(78)	(63)	(73)	(305)	22	254	(872)	(1,115)	(216)	(899)	(2,381)	(3,280)
	Total Plan	1,709	1,678	2,964	3,586	2,602	3,988	3,500	3,344	3,462	3,790	3,446	4,414	16,527	38,482	15,609	22,873	10,042	32,915
	Total Actual/Forecast	1,068	1,390	2,511	3,006	2,128	3,687	2,984	2,742	2,867	2,938	2,963	4,334	13,790	32,617	15,113	17,504	7,110	24,614
	Total Variance	(641)	(288)	(453)	(580)	(474)	(301)	(516)	(602)	(595)	(852)	(483)	(80)	(2,737)	(5,865)	(496)	(5,370)	(2,932)	(8,301)

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	3,145	3,403	0	**6,548**	716	0
Scheduled Care	4,466	3,089	0	**7,554**	167	0
Unscheduled Care	50	125	0	**175**	0	0
Mental Health	764	911	0	**1,675**	0	0
Community Services	1,066	410	0	**1,476**	0	0
Primary Care	213	2,800	0	**3,013**	0	0
Commissioned Services - CHC	0	610	0	**610**	0	0
Commissioned Services - Specialised Services	0	1,212	0	**1,212**	558	0
Other Commissioned Services	0	0	0	**0**	0	0
Clinical Support	1,465	2,047	0	**3,512**	611	600
Non Clinical Support	34	0	0	**34**	0	0
Executive / Corporate Areas	544	1,793	0	**2,337**	496	1,032
Total	**11,747**	**16,399**	**0**	**28,146**	**2,548**	**1,632**