CARDIFF AND VALE UNIVERSITY HEALTH BOARD

PUBLIC FINANCE & PERFORMANCE COMMITTEE 18TH NOVEMBER 2026

Start time: 10:00	1	Welcome, Introductions & Apologies for absence:	Assurance / Approval or Noting&Information (please put one)	Presenters
	1.1	Declarations of Interest		Rhian Thomas
	1.2	Minutes of the last meeting held: 21st October 2026		Rhian Thomas
	1.3	Action Log – following meeting held on: 21st October 2026		Rhian Thomas
	1.4	Chairs Actions since previous meeting		Rhian Thomas
10:05	**2**	**Items for Assurance**		
10:05 *25 Mins*	2.1	Operational Performance Update	**Assurance**	Paul Bostock
10:30 *20 Mins*	2.2	Financial Report – Month 7 Position	**Assurance**	Andrew Gough
10:50	**3**	**Item for Approval / Ratification**		
10:50 *15 mins*	3.1	Planning Maturity Self-Assessment	**Approval**	Adam Roberts
11:10 *5 mins*	3.2	Adult ICU Programme Business Case	**Approval**	Catherine Phillips
11:15 *5 mins*	3.3	UHB 148 v3 Intellectual Property Rights Policy	**Approval**	Mark Briggs / David Fluck
11:15	**4**	**Items for Noting and Information**		
0 mins	4.1	Monthly Monitoring Return – Month 6	**Noting**	Andrew Gough
0 Mins	4.2	Q2 RPB Performance and Finance Report 2026/27	**Noting**	Adam Roberts
	5	**Private Committee Business**		
		• PwC Update on Turnaround Work • Financial Forecast Update • 3-year route to financial sustainability		Rhian Thomas
11:20	**6**	**Any Other Business**		
	7	**Review of Meeting**		

	7.1			Rhian Thomas
	7.2	**Time and date of the next meeting:** Wednesday January 20th 2027 via MS Teams		
	7.3	**Declaration before moving into private session:** *To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960]*		

Minutes of the Public Finance & Performance Committee Meeting
21st October 2026
Via MS Teams

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

Chair:		
Rhian Thomas	RT	Independent Member – Capital, Estates & Facilities
Present:		
Kirsty Williams	KW	CAV UHB Chair
Lorna McCourt	LM	Independent Member – Trade Union
David Edwards	DE	Independent Member – Digital
Judi Rhys	JR	Independent Member – Third Sector
Susan Lloyd-Selby	SLS	Independent Member – Local Authority
Chris Bown	CB	Interim Chief Executive
Adam Roberts	AR	Executive Director of Strategic Planning
Paul Bostock	PB	Chief Operating Officer
Matt Phillips	MP	Director of Corporate Governance
Andrew Gough	AG	Deputy Director of Finance (Strategic)
Mike Bond	MB	Director of Operations – Urgent & Emergency Care
Robert Mahoney	RM	Deputy Director of Finance
Secretariat:		
Nikki Regan	NR	Corporate Governance Officer
Observers:		
Jane Brown	JB	Interim Head of Corporate Governance
Apologies:		
Steve Riley	SR	Independent Member – University
Clive Curtis	CC	Independent Member - Community
Rachna Upadhya	RU	Independent Member – General
Ceri Phillips	CP	CAV UHB Vice Chair

Ref:	Agenda Item:	Action
FPC 21.10/1.1	**Welcome, Introductions & Apologies** Rhian Thomas (RT) Committee Chair welcomed everybody to the meeting in English and in Welsh.	
FPC 21.10/1.2	**Declarations of Interest** No declarations of interest were raised.	
FPC 21.10/1.3	**Minutes of the Finance and Performance Meeting held on 16th September 2026** The minutes of the meeting held on 16th September 2026 were received and confirmed as a true and accurate record. **The Finance Committee resolved that:** a) The minutes of the Finance and Performance Committee meeting held on 16th September 2026 were held as a true and accurate record of the meeting.	
FPC 21.10/1.4	**Actions following the Finance & Performance Meeting on 16th September 2026** PB apologised for his actions not coming through.	

	The Finance and Performance Committee resolved that: a) The Action Log for the Finance and Performance Committee was noted.	
FPC 21.10/1.5	**Chairs Action since previous meeting** There were no Chair's Actions taken since the last meeting	
FPC 21.10/2.1	**Financial Report – Month 6 Position (including savings tracker)** The Deputy Director of Finance – Andrew Gough (AG) highlighted the following points regarding the Financial Report: • **Forecast deficit:** Welsh Risk Pool contribution fell by £9.1m, revising the forecast deficit from £86.5m to £77.4m. This was a timing change, not a reduction in the underlying liability; the actions needed to deliver the forecast remained unchanged. • **Month 6 position:** The year-to-date deficit was about £46m, around £7.7m worse than the profiled position. The variance was mainly a £10.3m shortfall against planned savings, partly offset by a £2.6m operational surplus. • **Savings delivery:** The savings target was £47.6m. About £27m of schemes were rated green or amber, leaving a £20.6m gap; recurrent savings were £20.7m, leaving a £26.9m recurrent shortfall. • **Recovery outlook:** The forecast deficit before recovery actions was £87.9m, leaving a £10.5m gap against the revised forecast. Roughly half of the red savings pipeline would need to be delivered to get back on track. • **Underlying and cash position:** Without further improvement, the projected starting deficit for next year would be £104.3m. September cash was £3.3m, and CAVUHB expected to seek £77.4m in strategic cash support from Welsh Government (WG). • **Other financial matters:** £87.8m of expected allocations were still unconfirmed; capital slippage review included about £1.9m relating to Parkview; payment compliance was 96.5% against a 95% target. RT noted the Welsh Risk Pool contribution had changed significantly mid-year last year and was changing again this year, making future-year forecasting difficult. She asked what confidence and assurance there was for the next financial years. AG said the change reflects both the number of cases expected and a one-percentage-point reduction in the health board's share of costs. NWSSP did not yet have a clear position for next year, and there was no assurance on the next 18 months; he said at least three-year modelling was needed. The Independent Member Local Authority – Susan Lloyd-Selby (SLS) queried why clear ownership and implementation milestones were still being established, and whether some savings opportunities lacked them. AG confirmed that once the red-pipeline schemes are agreed for progression, they need to be assessed for deliverability, assigned owners and given accountability arrangements. Th Executive Director of Finance – Catherine Phillips (CP) highlighted the following: • Clinical-board ideas in the red pipeline total about £5–6m and need developing into deliverable plans; red schemes may not yet have owners or delivery milestones. • The two larger schemes are the workforce plan—including understanding the actions needed to address workforce growth—and the bed plan. • The three areas to work through are the clinical-board ideas, workforce actions, and bed-plan work, with a shared understanding between the organisation and budget holders of what is required and what is achievable. RT raised the £5.1m JCC savings target and asked for an update on the expected JCC contribution and progress towards achieving it. AG said about £1m of identified savings related to the JCC target, but joint work had not yet developed sufficiently. Chris added that no active discussions had taken place.	

	The CAVUHB Chair – Kirsty Williams (KW) noted differing performance across clinical boards and asked whether support and scrutiny could focus on boards facing greater challenges with savings and staying within budget—particularly Women and Children—and on areas receiving less Board-level discussion. AG said savings targets had initially been allocated relatively evenly, without a full plan, and that the organisation needed to assess the realistic savings opportunities in each area. Paul added that the JCC impact was concentrated in Women and Children and specialist services, so next year's targets should reflect what is achievable The Executive Director of Strategic Planning & Partnerships – Adam Roberts (AR) said the intention was to avoid flat savings requirements across clinical boards next year. Chris highlighted cross-cutting opportunities, including the bed plan, length of stay and workforce reductions. The Interim Chief Executive – Chris Bown (CB) agreed with AR and noted that the cost-improvement priorities included cross-cutting schemes—particularly the bed plan and length-of-stay reduction—and that substantial work had been done with PwC on these financially significant areas. The Chief Operating Officer – Paul Bostock (PB) said Children and Women (C&W) and Specialist had the largest variances, with most of the £5m impact falling on those boards. He said C&W should be challenged on what they can deliver, but the £6.1m target was not achievable for them; next year's planning should set realistic expectations and avoid setting teams up to fail. **Action – (AG) Red savings pipeline - Add a review of which schemes are viable and can deliver savings this year; the committee asked for a clearer view of feasibility.** **The Finance and Performance Committee:** a) Noted the reported year to date position is an overspend of £46.4m with a year-end forecast deficit of £77.4m. b) Noted there is an urgent need to de-risk the £77.4m revised forecast deficit. There is a £10.5m gap to delivery. c) Noted that at Month 06 there is an adverse variance of £7.7m against the revised forecast, driven by a £10.3m savings deficit, partially offset by an operational surplus of (£2.6m). d) Noted the core savings target of £42.5m is fully covered, however, there is an associated material delivery risk linked to the £20.4m of red-rated schemes. Further work is being progressed with JCC to identify opportunities to address the additional £5.1m JCC 2% efficiency target e) Noted that the forecast remains dependent on the delivery of further financial mitigations, with material risks continuing in relation to the savings programme and the recurrent financial position. The Welsh Risk Pool adjustment has been assumed to provide a recurrent benefit to the underlying position. f) Noted there are £87.8m of outstanding resource limit allocations and that in due course the UHB expects to seek Finance Committee and Board approval to request £77.4m strategic cash support from WG to support the forecast deficit.	
FPC 21.10/2.2	**Operational Performance Update** The COO highlighted the following points on the Operational Performance Update: • **Planned care:** 6,854 patients remained in, or were expected to enter, the two-year-wait cohort by year-end, compared with a planned 8,478 at that point; the overall cohort was ahead of plan. • **Cancer and diagnostics:** Cancer performance was being maintained, with the backlog recently falling; diagnostics remained challenging but was progressing against plan.	

- **Urgent and emergency care:** Delays in the emergency pathway, specialist reviews, ward admission and discharge, contributing to longer stays. He said an external review had validated these issues.
- **Improvement actions:** CAVUHB was focusing on seven-day working, timely clinical reviews, criteria-led discharge and a winter task force.
- **Business continuity:** A continuity incident was declared after ambulance waits reached almost five hours; CAVUHB would review the causes and actions to prevent recurrence.
- **Stroke:** Concerns about performance and said the team would review immediate pathway changes and hold a follow-up meeting to assess progress.

CB made these points while discussing urgent and emergency care improvement: waiting times must remain a priority; the focus should shift from describing problems to implementing known solutions; internal practices contribute to operational pressure, so pathways need more consistency; and the organisation should act firmly and hold delivery to account.

AR made this point during the urgent and emergency care discussion: he said the five ambulances waiting outside the hospital contributed to calling a Business Continuity Incident (BCI), and stressed that delays there can prevent ambulances reaching people in the community. He noted that some UK areas accept such waits as normal but said the Board should recognise the risk level that prompted its BCI.

KW agreed that calling a business continuity incident reflected the CAVUHB's expectations for managing risk. She noted significant improvement in clinical coding and strong performance in some mental health services, alongside progress in other areas. She said some performance measures were not improving despite added funding, staff and plans, and asked how to bridge the gap between staff's pressured day-to-day experience and the changes being sought. She framed the ask as better, more streamlined and more effective use of staff's skills and effort—not simply asking them to do more. She asked what is preventing implementation and what levers could help deliver change, improve staff working conditions and outcomes for patients.

CB raised this while discussing how to implement the agreed policies: follow up on delivery, hold people to account, and address non-delivery by understanding the issue and putting it right.

PB described a long-standing culture in which poor performance was accepted as unavoidable. He said change cannot depend on a few leaders alone: more colleagues need to support and model better ways of working. He also noted that many staff believe there is not enough money or staffing and stressed the need to move quickly because patients need better care.

The Independent Member Trade Union – Lorna McCourt (LM) mentioned her 15 years of experience in the private sector and NHS England, then asked to be involved early in the work. She emphasized involving staff-side and trade union representatives from the outset to help engage staff.

SLS asked how patients' voices were being included and whether CAVUHB was engaging with Llais.

PB said CAVUHB needs a broader conversation about improving patient involvement. He noted that it can be hesitant to involve patients in service changes and that patients' own perspectives should be included.

Action – (PB) - To report on how the ambulance-waiting incident occurred, what could have prevented it, and the actions to reduce recurrence.

The Committee resolved that:

a) The position against key organisational indicators for 2026-27 and the update against the Operational Plan programmes were noted.

FPC 21.10/2.3	**UEC Hospital Flow & Discharge** The Director of Operations for Urgent & Emergency Care – Mike Bond (MB) highlighted the following points: a) **Aim:** Improve flow by making ward practice more consistent, with reliable daily board rounds, clear discharge plans and follow-up of actions. Mike said this was not happening consistently across wards. b) **Pilot wards:** The programme was tested on six wards across medicine, trauma, surgery, cardiology and neurology. Standard operating procedures were issued, and board rounds, potential discharge dates, red-to-green reviews and afternoon huddles were introduced. c) **Discharge and length of stay:** Earlier discharge—including at weekends—and criteria-led discharge are intended to reduce avoidable hospital days, release capacity and support safer care at home. d) **Early results:** Across the six wards, discharges were up 10% over the latest six weeks compared with the January–March average, but results varied between wards. During the BCI period, discharges increased by 22% across the four days. e) **Monitoring:** Measures include board-round compliance, recording discharge dates, red-to-green status, afternoon huddles, criteria-led discharge and length of stay. Weekly results and a four-week rolling view are being used, with named owners in each clinical board. f) **Current challenge and rollout:** The foundations are in place, but use of the standards is uneven. The next phase is to test the approach on more wards, evaluate it and extend it through winter; Mike identified staff sickness and workforce gaps as risks to consistency. g) **Weekend discharge:** Mike said improvement depends on planning on Fridays, enabling weekend teams to discharge patients, and following up with clinical and operational leads where actions are not completed. He noted that weekend discharges rose by around 40% during the BCI. KW asked what prevents better weekend performance, whether the levers sit beyond the organisation, and what happens if people do not take part. MB said improvement was possible within the organisation: plan discharges on Friday, use criteria-led discharge, empower weekend teams, and follow up with individuals who are not meeting expectations. He said this needs consistent clinical and operational accountability. PB noted that weekend staffing can be changed for non-medical staff; consultant weekend work needs to be addressed through job planning. He said non-compliance may require an accountability process, as the expected way of working is not optional. SLS thanked Mike for the report and asked whether the 33% target was based on clear evidence it was achievable. She also asked about staff support and whether there was resistance. MB said resistance was limited, with engagement particularly among nursing teams. He noted some issues with consultants, being addressed through clinical directors, and said the key challenge was sustaining consistent practice. PB added that some staff may see more discharges as creating more work and admissions, so views were not uniformly positive. LM raised this during the ward-flow discussion: she asked whether discharge medication is included in the discharge process, noting that not all services operate full days, seven days a week. **The Committee resolved that:** a) Take assurance from the controlled implementation and oversight arrangements; b) Confirm Clinical Board accountability for delivery, audit and recovery action; and	

	c) Note that the Winter Plan capacity contribution remains at risk until improvement is evidenced and sustained.	
FPC 21.10/2.4	**Q2 Annual Plan Report** AR highlighted the following points on the Q2 Annual Plan Report: • **Overall position:** Confidence in the annual plan was lower than in Q1, with fewer actions rated positively; this was not translating into the patient-performance improvements needed. • **Refocusing priorities:** The integrated improvement plan was being tightened, with support from NHS P&I following the independent assessor's report. Priorities included reducing two-year waits, improving length of stay, financial turnaround, building foundations for Community by Design, and implementing the quality management system. • **Two-year waits:** There was a plan to deliver the target and that the executive team would monitor it more closely, using regular, data-led discussion at senior leadership meetings. • **Length of stay:** An improvement programme was starting on Ward A7, with rollout planned to seven more wards and work to implement GIRFT recommendations. • **Next year's planning:** Stronger planning and delivery to organisational redesign, improved shared understanding of performance, and a stronger performance-management framework. • **Organisational redesign capacity:** The board hoped to appoint a redesign director within a couple of weeks, then build a team to strengthen delivery of major change programmes. • **Committee outcome:** The committee was asked to note the Q2 report's progress and approve submitting the Q2 position to Welsh Government. RT noted this during the Q2 annual plan discussion: the Q3/Q4 outlook was being reviewed and feeding into the P&I work. AR linked delivery of the plan to building stronger planning, performance and commissioning capability through the organisational redesign. He said ongoing discussions would address improvements this year, and described the redesign as a fundamental priority to progress quickly. SLS raised the need for capacity to support the workforce and organisational redesign, asking when progress could be expected. Adam said they hoped to appoint the redesign director within the next couple of weeks, then build a team around them to lead the work. No overall completion timeline was given. **The Committee resolved that:** a) The progress highlighted in the Q2 Annual Plan Report was noted b) The submission of the Q2 position to the Welsh Government was approved.	
FPC 21.10/3.1	**Mental Health and Community Information System** The Director of Digital & Health Intelligence – David Thomas (DT) highlighted the following points on the Mental Health and Community Information System: • It was a procurement to replace an ageing system; it had been reviewed twice by the Value and Benefits Realisation Group and discussed in depth at SLT. • Welsh Government funding of £6m over three years had been secured. A revenue cost—discussed as around £500k a year—would need to be covered from year four. • Workshops with affected clinical boards explored potential cash-releasing and time-saving benefits; year-one funding had been received, and procurement was on a tight schedule. • The committee expected the benefits plan to be developed and delivered, with benefits reviewed and tracked—particularly in financial terms—before full rollout. RT noted if the committee recommended it to the Board, the recommendation should be conditional on continuing and completing the work to identify savings to offset the £500k annual recurring cost as soon as possible.	

	CP noted that DT had been working with the clinical boards on administrative processes and time-releasing benefits. A high-level reduction in administrative and clerical staffing was identified and signed off, but the detailed savings still needed confirmation by the relevant teams. RT noted to change one of the benefit realisation plans. **The Committee noted that:** a) Endorse progression of the business case to Board. b) Note the extensive engagement undertaken across Clinical Boards, Finance and Digital teams. c) Recognise unanimous agreement among Clinical Board stakeholders that replacement of the PARIS Electronic Patient Record is essential to maintain safe and effective service delivery beyond March 2029. d) Note that the current Outline Business Case identifies an estimated additional recurrent revenue requirement of approximately £514k per annum from 2029/30 onwards, subject to confirmation through the procurement process. e) Acknowledge that this recurrent funding requirement is not currently reflected within the Health Board's approved financial plan and will require consideration through future financial planning arrangements. f) Note that benefits realisation opportunities have been identified but have not yet been developed into quantified cash-releasing savings plans g) Expecting the continued development of benefits realisation plans by benefiting Clinical Boards, working with the programme team and Finance colleagues, to identify, quantify and deliver productivity, efficiency and cost avoidance opportunities. h) Endorse progression of the business case and continuation of procurement activity to avoid unacceptable delays, increased organisational risk and potential loss of Welsh Government funding (current and future FY).	
FPC 21.10/4.1	**Monthly Monitoring Return** This item was noted.	
FPC 21.10/5.0	**Any Other Business** No further business was raised.	
FPC 21.10/6.0	**Review & Close** To note the date, time and venue of the next Committee meeting: **Wednesday 18th November 2026 via MS Teams**	

MEETING	Title	Minute Reference	Agreed Action	Executive Lead	Action Lead	Date Assigned	Date for Review	Action Status	Action Update	Comments
FINANCE & PERFORMANCE	Diagnostic Deep Dive	FPC 16.09/2.4	To develop phased implementation plan for Welsh Government outpatient reforms with clinical engagement and operational delivery approach.	Paul Bostock	Catherine Wood EA to Chief Operating Officer	16/09/2026	20/01/2027	ON FORWARD PLAN	Added to the forward plan / agenda for 20.01.2027.	
FINANCE & PERFORMANCE	Diagnostic Dep Dive	FPC 16.09/2.4	To develop a fully costed diagnostic demand & capacity plan (including recurrent funding requirements) for return to committee (target end of Q3).	Adam Roberts Paul Bostock	Catherine Wood EA to Chief Operating Officer	16/09/2026	20/01/2027	ON FORWARD PLAN	This has been added to the forward plan for 20.01.2027.	
FINANCE & PERFORMANCE	Finance Position - Month 6	FPC 21.10/2.1	Red savings pipeline - Add a review of which schemes are viable and can deliver savings this year; the committee asked for a clearer view of feasibility.	Catherine Phillips Andrew Gough	Andrew Gough	21/10/2026	18/11/2026	ON FORWARD PLAN	This has been added to the forward plan for 18.11.2026.	This is to be included in the Finance monthly report.
FINANCE & PERFORMANCE	Operational Performance Update	FPC 21.10/2.2	To report on how the ambulance-waiting incident occurred, what could have prevented it, and the actions to reduce recurrence.	Paul Bostock	EA to Chief Operating Officer Paul Bostock	21/10/2026	18/11/2026	ON FORWARD PLAN	This has been added to the forward plan for 18.11.2026.	This is to be included under the Operational Performance Update.
FINANCE & PERFORMANCE	MHCS Business Case	FPC 21.10/4.1	To continue development of the MHCS benefits realisation plans, identifying and quantifying savings to mitigate the recurrent revenue cost and establishing arrangements to track delivery of those benefits.	David Thomas	David Thomas	21/10/2026	18/11/2026	ON FORWARD PLAN	This has been added to the forward plan for February 2027 to bring back to F&P with an update.	

Report Title: *(needs to match agenda)*	Operational Performance Update		Agenda Item No:		2.1
Meeting:	Finance and Performance Committee	Public	x	Meeting Date:	18.11.2026
		Private			
Lead Executive Title:	Chief Operating Officer				
Report Author/s Title:	Head of Performance				

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

ADVISE *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

The operational performance measures in the IPR bring together National Performance Framework measures, Targeted Intervention de-escalation criteria and internal performance metrics. These measures span urgent and emergency care, cancer, planned care, diagnostics and mental health. Performance against the standards varies across each area and are described with actions as part of the submission.

ASSURE *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

Board/Committee Response Required ***(please select only one)***

To confirm the action Members are being asked to take considering the AAA Framework

Assurance	x	**Approval**		**Information/Noting**	

Recommendations

Recommendations should be clear, actionable, and aligned to the AAA summary above.

a) Committee is requested to NOTE the position against key organisational performance indicators for 26-27 and the update against the operational plan programmes

Governance Route ***(please list all other Committee/Groups this report has been to)***

***Where** it's been:*	*N/A*
***When** it went:*	*N/A*
***What** decision was made:*	*N/A*

Main Report

Background & Current Situation

Urgent and Emergency Care

September and October have seen periods of operational pressure, with attendances increasing in October and remaining above the volumes seen during the same months last year. The number of 45-minute ambulance holds remained largely unchanged and remains below our de-escalation standard. The percentage of patients waiting 12h in EU reduced from 8.9% in September to 7.8% in October, but remains above our de-escalation standard of 7%. The UHB declared a Business Continuity Incident between 13-16th of Oct, the evidence and learning pack presented to SLT is included as an appendix.

Stroke and Hip Fractures

Door to ward compliance for the Stroke unit was challenged through Q2 and into Q3. Performance deteriorated to 42.9% in September but remains above the Wales average. 14.3% of patients received thrombolysis, improved from August. In September 21.9% of hip fracture patients were admitted within 4 hours, remaining above the UK average of 10%.

Delayed Pathways of Care

October saw an expected fall in Delayed Pathways of Care to 151. This remains above our de-escalation criteria of 128. The average days delayed increased from 50 in September, to 53 in October but the total bed days lost was reduced by 125 from September and by c1800 from October '25. Assessment issues and social worker allocation accounted for two thirds of the recorded delays in month.

Coding

We have seen an increase in % of coded episodes within 1-month. In the most recent national data we reported 84.1% compliance in July, significantly improved from the 51.9% reported in July '25.

Cancer

Following focused work to reduce the number of long waiting patients, compliance with the SCP reduced below our de-escalation requirement to 51.8% in September. The total waiting list remains increased from last year, however, in recent weeks we have seen a 25% reduction in the 62-day backlog and are ahead of our trajectory. We have taken actions in key tumour sites, with additional action planned in year including additional theatre lists for GI surgery and consultant capacity in Breast and Skin. In September, 3 tumour sites met the SCP standard of 75%; Skin, Haematology and Brain/CNS.

Planned Care and Diagnostics

Waits for NOP remains reduced. We have seen increases in 2y waits, in-line with our forecast; driven by Dermatology, General Surgery and Orthopaedics. In October we reported c1400 patients waiting 104 weeks or more. We have mobilised our plans to utilise the additional funding to reduce 104 weeks waits this year, we are currently c1800 patients ahead of trajectory for the cohort of patients to be seen by March '27. The number of 3y waits remains zero.

Diagnostic 8w waits increased in September, driven by endoscopy and radiology. This represents 48% of patients waiting less than 8w, below our de-escalation standard of 80%. We

have plans to mitigate including endoscopy insourcing, and additional capacity for CT, MR and NOUS. October's validated position can be updated at committee.

Mental Health Measures
Our compliance against the Mental Health Measures – Part 1a (assessment) and 1b (therapeutic intervention) remains strong. Part 2 (care and treatment plan) compliance remains over 95% for CYP. Adult services saw rapid progress against the action plan. Following a plateau at c70% in Q1, work to redistribute the CTPs within teams has seen further improvements to compliance in Q2.

Appendices:
(List any appendices that will accompany this report).

IPR Performance metrics
Business Continuity Incident (October 26) update
CAV Winter Plan Refresh

Strategic Alignment – Shaping Our Future Wellbeing:
Please place an "X" against the strategic objective(s) this paper supports – Click the below tiles for further information.

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

Impact Assessment
Please ensure each section is completed. (If "Yes" is selected, complete the detail. If "No", please write "Not applicable".)

Risk: No

If yes, please include the details of any Risk Assessments undertaken and, where appropriate, the nature of any risks identified. (If this has been addressed in the main body of the report, please say so).

Safety: No

If yes, what are the Staff or Patient safety implications associated with the content/proposals within this report. Have these been fully considered and are plans in place to mitigate them? (If this has been addressed in the main body of the report, please say so).

Financial: No

If yes, what are the financial implications associated with the content/proposals within this report? Have these been fully considered and are plans in place to mitigate them? (If this has been addressed in the main body of the report, please say so).

Workforce: No

If yes, what are the workforce implications associated with the content/proposals within this report? Have these been fully considered and have plans been put in place to mitigate them? (If this has been addressed in the main body of the report, please say so).

Legal: No

If yes, what are the legal implications that arise from the content/proposals within this report? Has advice been sought and what was the outcome? (If this has been addressed in the main body of the report, please say so).

Reputational: No

If yes, what reputational risks are associated with the content/proposals within this report? Have these been fully considered and have plans been put in place to mitigate them? (If this has been addressed in the main body of the report, please say so)

Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*

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

Equality & Health: No

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

Decarbonisation: No

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

- *A focus upon preventing ill health in our population*
- *Saving energy or increasing throughput.*
- *Value based healthcare.*
- *Patients empowered to manage their conditions, utilising See on Symptoms and Patient Initiated follow ups to reduce unnecessary appointments.*
- *Service delivery in the most appropriate setting*
- *Reducing waste*

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

Welsh Language: No

Consideration should be given to potential impact on the Welsh language

- *Does the report align with the More than just words strategy, ensuring Welsh-speaking patients can access services in their preferred language?*
- *Ensure key information is bilingual and that the report meets the Welsh Language Standards for communication, signage, and patient materials.*
- *Does the report address the need for Welsh-speaking staff or bilingual resources to deliver equitable care?*

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

SLT EVIDENCE AND LEARNING PACK

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

October Business Continuity Incident

What led us to this point?

June context → October indicators → discharge failure → safety impact → BCI actions → what must now be sustained

Prepared for Senior Leadership Team

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

The story in one line

The October BCI was not driven by increased attendances or admissions alone. It followed a loss of inpatient flow resilience, most visibly in Medicine, which translated into congestion, prolonged waits and escalating clinical risk.

1

June reminder

Demand rose faster than flow gains

2

Pre-October warning

Discharges reduced with increased variation

3

October pressure

Admissions exceeded discharges and length of stay rose

4

Safety impact

Crowding, delay and deterioration risk

5

BCI response

Senior grip, tracking and escalation

6

Sustain

Turn incident behaviours into business as usual

Key distinction: June is context. The September/October operating position is the direct cause for BCI.

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

What June told us

+2.1%
Attendances: Year on Year increase in first quarter

+3.3%
Admissions: Year on Year increase in first quarter

+2.7%
Discharges: Year on year increase in first quarter

−0.67 days
LOS: Year on Year decrease in first quarter

212 → 231
average weekly 12h breaches

Front door improved

Ambulance conveyances reduced by 6.2%; one-hour holds reduced from an average 93 to 17 per week; CAV 24/7 activity increased.

Flow gains were insufficient

Discharges and LoS improved, but admissions increased faster and long waits worsened. Medicine admissions rose 4.7% while discharges rose 1.8%.

Community contribution weakened

CRT referrals fell 13.7%; Safe@Home accepted referrals fell 27.5%; reported bed days saved fell 32.1%.

June takeaway: the system had improved parts of the pathway, but did not yet have enough reliable flow to absorb rising pressure.

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

What changed as October approached

3,124
Weekly **EU attendances** increased by 5% over the last two years

+16.6%
October **Eu attendances** above weekly average

4,008
August emergency admissions
+3.8% vs August 2025

4,334
September emergency admissions
+3.7% vs September 2025

119
Geriatric admissions September 2026
+20.2% vs average

Medicine length of stay review

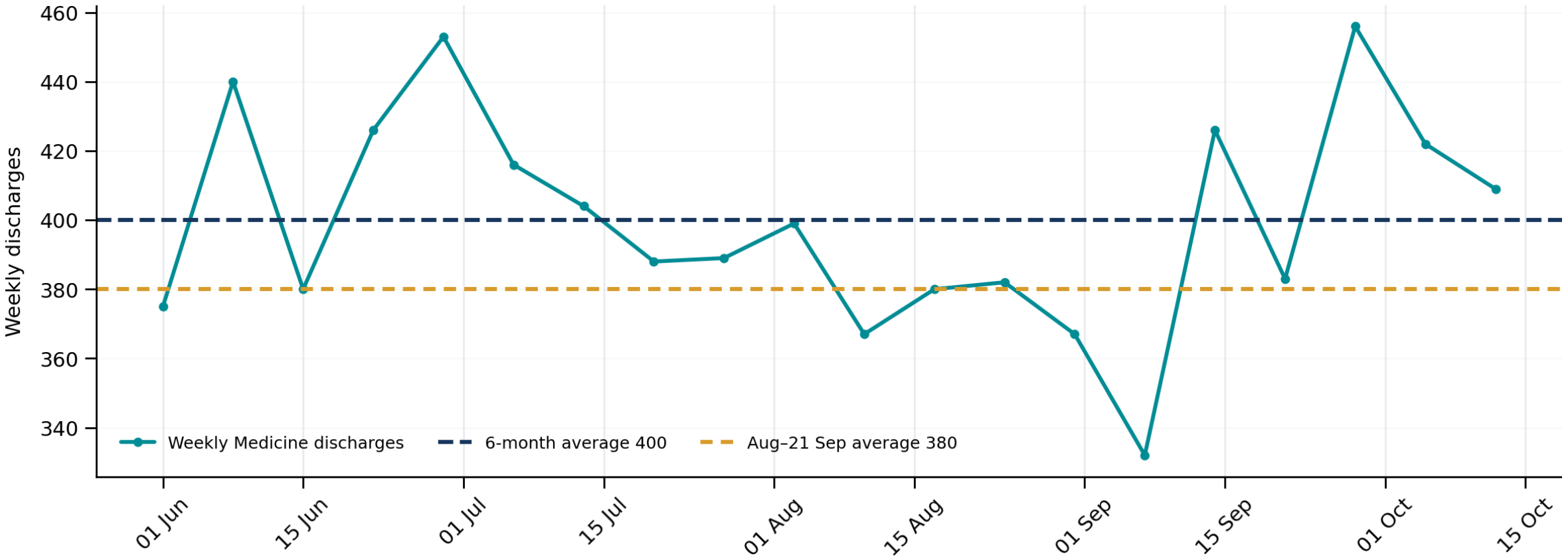
Medicine LoS rose from 12.1 days in July to 14.6 in October (1–21), despite a temporary improvement in September. October was 1.0 day longer than the same period in 2025 (13.6 days).

Average Medicine LoS, excluding same-day stays

	July	August	Sep	Oct 1–21
2025	14.8	13.3	12.4	13.6
2026	**12.1**	**13.5**	**13.1**	**14.6**

Emergency admissions were 3.8% above last year in August and 3.7% above in September. Medicine LoS reached 14.6 days in October (1–21), compared with 13.6 days in the same period last year.

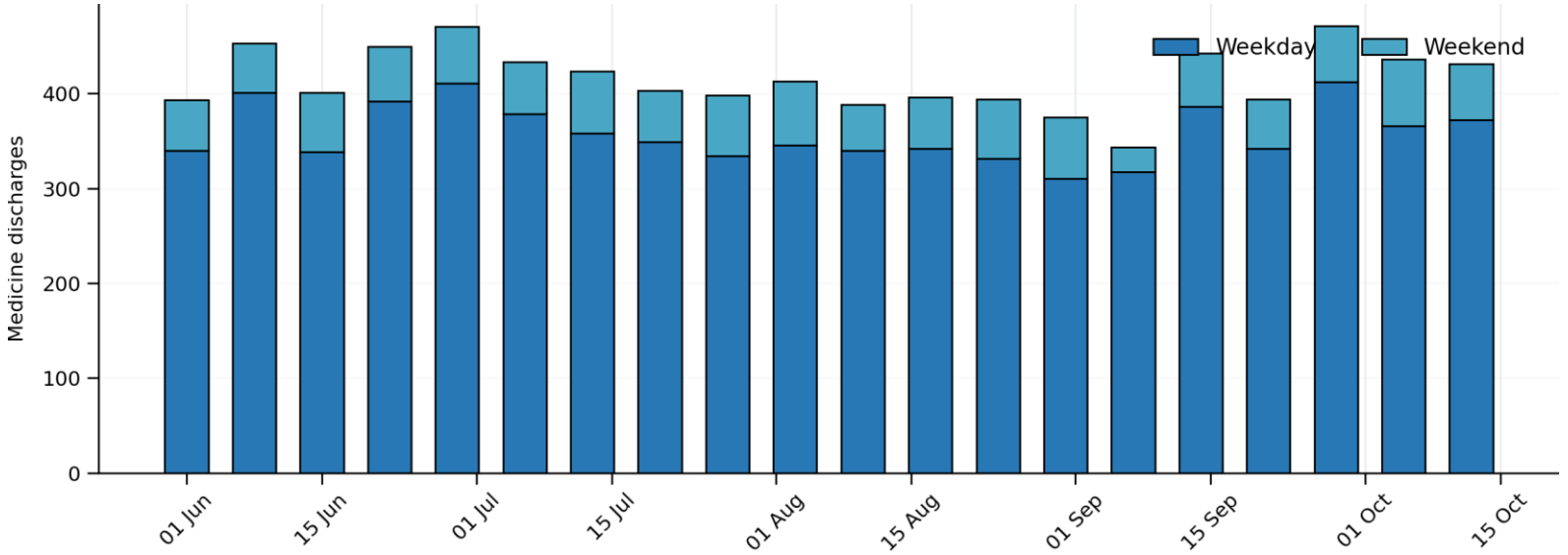
Medicine discharge output weakened before BCI



The 6-month average was 400 discharges per week at 12 October. The August to 21 September average was 380, below the six-month position. Both are shown as straight dotted reference lines.

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

The weekend profile amplified the flow risk



Daily discharge profile, 1 June–18 October 2026 (20 full weeks)

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Even weekly share	14.3%	14.3%	14.3%	14.3%	14.3%	14.3%	14.3%
Actual weekly share	16.0%	17.1%	17.6%	17.4%	18.2%	8.2%	5.5%
Avg discharges/day	66.4	71.0	73.1	72.2	75.6	34.1	23.0

Even share = 1/7 of weekly discharges. Actual shares use observed totals. Figures rounded.

Why this matters

Low weekend output reduces the bed base available for Monday and makes recovery dependent on unusually high weekday discharges.

Operational finding

BCI reviews found weekend ward rounds did not consistently identify patients ready for discharge; some remained awaiting medical review.

Interpretation

The risk was not one poor weekend. It was reduced and variable discharge reliability over multiple weeks.

How reduced flow translated into the October position

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

Reduced and variable medicine discharges

Less bed capacity released

Rising LoS and outstanding actions

Slower turnover and reduced resilience

Admissions exceeding discharges on key days

Net accumulation of patients

Outliers and escalation capacity

Specialty beds and assessment areas constrained

EU congestion and prolonged waits

Clinical risk increased

32	20	20	43	−45
EU waits >12h on 11 Oct	EU DTAs, 13 Oct 11:30	specialty referrals	medical outliers	medical bed balance

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

Why BCI was declared

The trigger was a material loss of operational control across the acute pathway, with immediate patient-safety risk and insufficient routine capacity to recover.

Immediate position

High EU crowding; 20 DTAs and 20 specialty referrals requiring action; substantial medical outlier burden; prolonged waits and reduced bed availability.

Underlying weakness

Poor weekend discharge performance over several weeks; rising LoS; delayed diagnostics, onward care and patient progression; inconsistent escalation.

Purpose of escalation

Create organisational focus, strengthen senior clinical oversight, accelerate decisions and release capacity across the system.

BCI used command arrangements to concentrate authority, resources and attention on patient progression. It was not simply a response to higher attendances.

The safety impact of congestion and delay

Prolonged exposure in EU

Long waits increased. Included 37 patients over 12 hours, 12 over 18 hours and one trauma patient reaching 24 hours.

Delayed triage and specialty review

Triage delays reached around 90 minutes at one point; identified risk where suspected stroke or other deteriorating patients waited for assessment or specialty action.

Deterioration and constrained care

Congestion reduced access to cubicles, specialty beds and timely senior decisions. Assessment areas, outliers, stroke and critical-care constraints compounded the risk.

Potential mortality impact

Congestion and delays can compromise patient safety and may lead to increased mortality. We have yet to test this relationship locally.

Safety proposition: reduced flow increased time spent in congested settings and delayed assessment, review and progression. That increases clinical risk, but patient-level harm and mortality attribution require formal review.

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

What we did during BCI

Senior clinical decisions

Consultant approval and additional senior review at front door, wards and outliers.

Patient-level grip

Daily trackers, 72-hour review, named actions, owners and predicted discharge dates.

Command and escalation

Bronze/Silver rhythm, rapid constraint escalation and explicit accountability.

Workforce and activity

Selected clinics, audit and meetings stood down or reprioritised; staff redeployed where useful.

Diagnostics

MRI, echo, ultrasound and reporting prioritised; escalation inboxes used.

Community and partners

CRT/VCRS, Safe@Home, local-authority and therapy support targeted to discharge barriers.

The common mechanism was faster ownership and decision-making, not simply more activity.

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

What changed during BCI

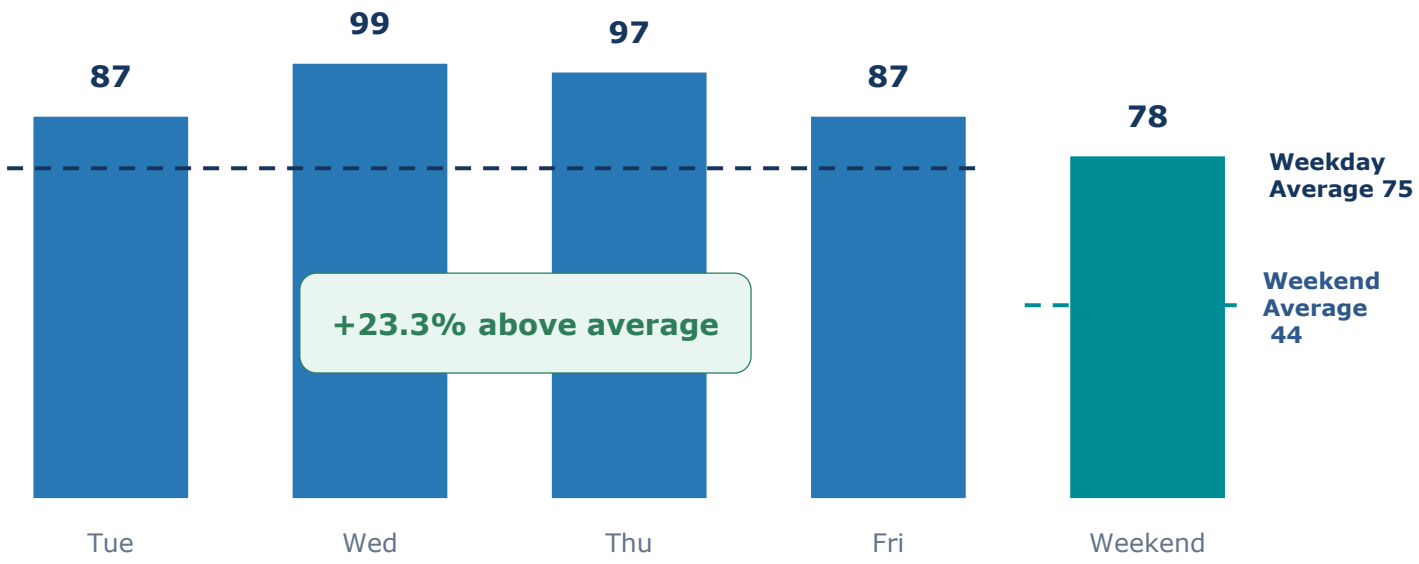
20 → 5
EU DTAs

20 → 8
specialty referrals

10 → 0
A1 Link waiting-room DTAs

370
Tue–Fri discharges

Recorded discharge profile | Actual Tue–Fri average: 92.5 per day



Interpretation

The direction of travel improved under BCI. However, these are snapshot measures and do not establish causation, quantify avoided harm or demonstrate that flow reliability was restored.

BCI created recovery momentum. The test is whether the behaviours and outcomes can be sustained without incident-level intervention.

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

What we learned

What worked

Patient tracking; faster escalation; visible senior oversight; command structures; ward-level focus and cross-board support.

What was inconsistent

BCI expectations, communication, stopped activity, service implementation, out-of-hours ownership and weekend coverage.

What was unsustainable

Parallel spreadsheets, duplicate meetings, exceptional leadership attention and asking teams to work harder without fixing systems.

The biggest impact came from visibility, accountability and senior oversight of patient progression, not simply from reducing elective activity.

Implication: these should become normal operating disciplines, supported by better information and clear roles.

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

What must now be sustained

Daily clinical grip

Senior ward review, PM huddles, named next action, owner and completion time.

Discharge reliability

Ward trajectories, earlier discharge, criteria-led pathways and explicit Friday/weekend plans.

Outlier standards

Consistent ownership, specialty continuity, ward-based discharge support and repatriation routes.

Referral discipline

Track time of referral, expected senior response, 90-minute escalation and completion.

One source of truth

Replace duplicate trackers; align definitions for clinically optimised patients, DTAs, outliers and discharge activity.

Downstream readiness

Medication, transport, equipment, therapy and community referrals completed before escalation.

Recovery should be measured by reliability across seven days, not a short burst of activity.

Response to BCI and Winter preparedness

BCI identified the operational failure. GIRFT and the UEC Improvement Plan provide the delivery framework to convert incident behaviours i

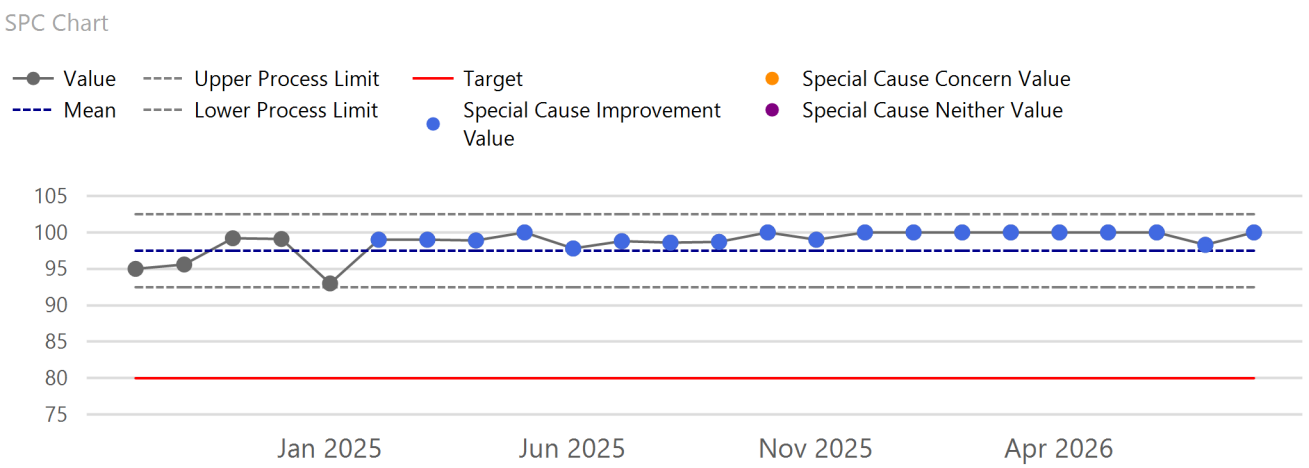
BCI finding / action	GIRFT / UEC Improvement response	Lead and completion	SLT assurance / decision
Congestion and avoidable EU demand	Co-located UTC and nurse-led streaming. Measures include UTC use, patients streamed away from EU, conversion and referral turnaround.	Clare Davies; Wayne Parsons; Jenelle Courtney; Rhys Andrews | Dec 2026	Assure streaming and UTC delivery; decide barriers relating to workforce, estate or diagnostics.
Delayed specialty response and unclear ownership	Acute Referral Policy / Clinical Operational Standard 6: timely specialty response, clear accountability and escalation.	Katja Empson / Omar; Rhian Grapes; Peter Burrow | Nov 2026	Assure referral and consultant response, escalation breaches, EU performance and outlier reduction.
Reduced and variable Medicine discharges	Criteria-led discharge across agreed pathways to reduce delay and improve earlier and weekend discharge.	Sandeep Berry; Emma Davies / Fiona Davies; Vicci Page | Dec 2026	Assure pathway implementation, eligible use, pre-midday discharge and weekend trajectory.
Weak seven-day continuity and Monday pressure	Consultant-of-the-week / Clinical Operational Standard 3: daily senior decisions, senior nurse cover and MDT ward/board rounds.	David Hanna; Ceri Phillips; Anne Marie Morgan | Mar 2027	Assure daily-practice compliance, LoS and discharge rates; escalate weekend-cover gaps.
Insufficient alternatives and bed-equivalent capacity	Virtual Smart Care: hospital-level care at home to support admission avoidance and earlier discharge.	Richard Lea; Emma Davies; Mike Bond | Jan 2027	Assure activity, readmissions and bed-equivalent capacity; resolve delivery dependencies.
OPAT contribution not yet defined	Review the OPAT operating model. Scope, outcomes, measures, leads and completion remain to be confirmed.	TBC	SLT decision: confirm scope, ownership, outcomes, measures and completion date.

SLT assurance: each workstream should report against its expectation, compliance measure, named lead and completion date, with material exceptions escalated for decision.

Metric ID: 10000015

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

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	95	80	P	H	Chief Operating Officer



Narrative

Consistently exceeding the standard, many months at 100% compliance

Actions and Owners

Sustained 100% compliance with Part 1A and Part 1B has been achieved through robust demand and capacity management, flexible deployment of clinical resource and continuous review of service capacity in response to changing demand. Psychoeducation Connection Contacts provide children and young people with earlier access to intervention while supporting delivery of the 28-day Part 1B standard

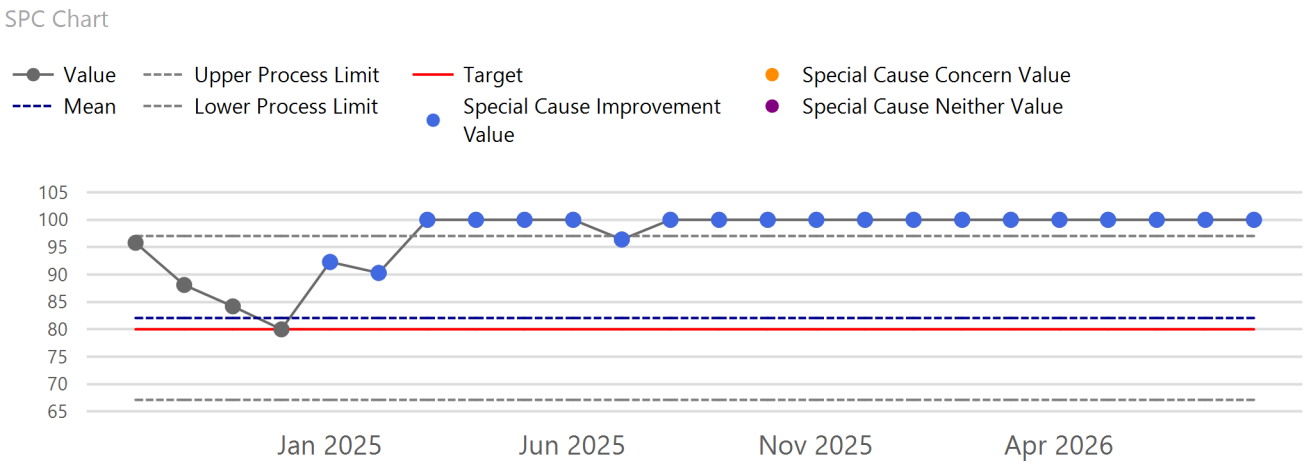
Concerns

n/a

Metric ID: 10000016

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

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	95.8	80	?	H	Chief Operating Officer



Narrative

Consistently exceeding the standard, many months at 100% compliance

Actions and Owners

Sustained 100% compliance with Part 1A and Part 1B has been achieved through robust demand and capacity management, flexible deployment of clinical resource and continuous review of service capacity in response to changing demand. Psychoeducation Connection Contacts provide children and young people with earlier access to intervention while supporting delivery of the 28-day Part 1B standard

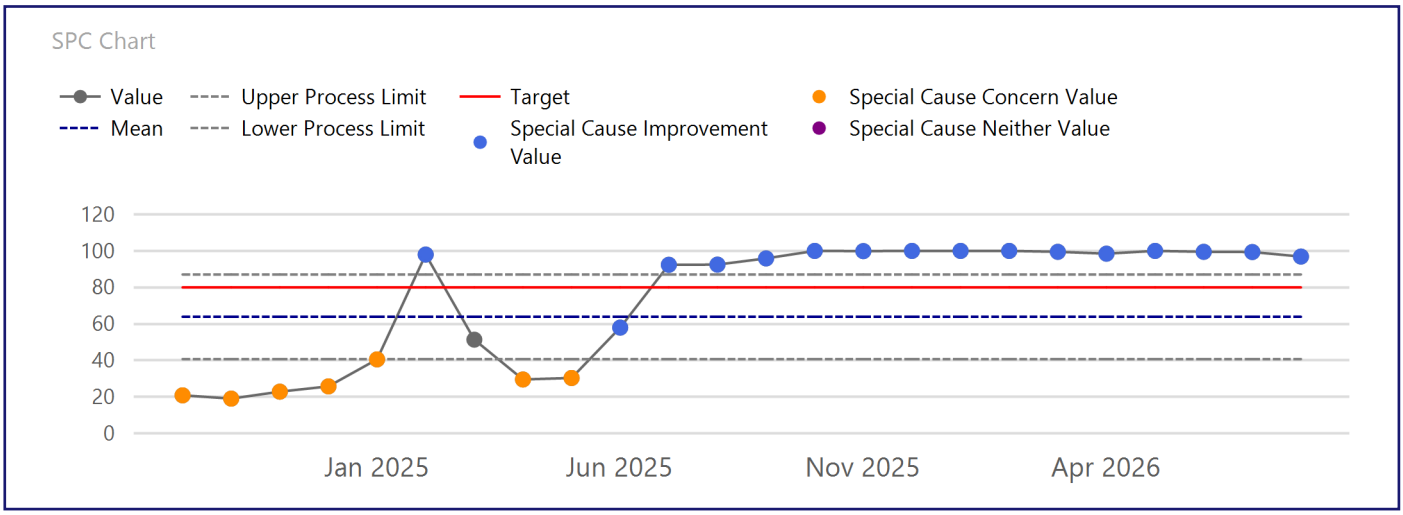
Concerns

n/a

Metric ID: 10000017

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

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	20.9	80	?	H	Chief Operating Officer



Narrative

Consistently exceeding the target

Actions and Owners

Internal flexibility to ensure sufficient assessments are completed

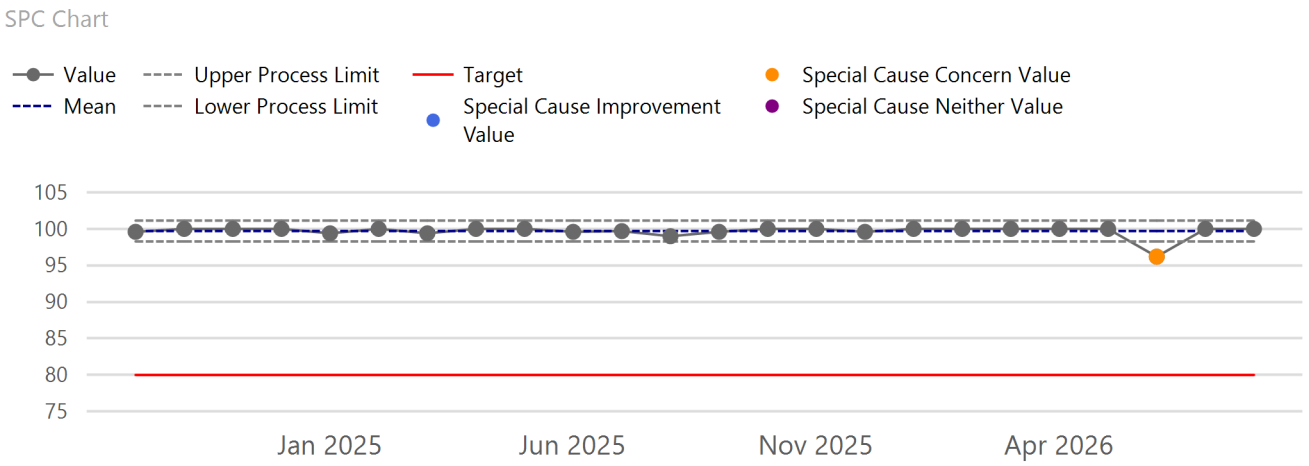
Concerns

Rise in long term sickness absence in PMHSS

Metric ID: 10000018

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

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	99.6	80	P		Chief Operating Officer



Narrative

Consistently exceeding the target

Actions and Owners

Development of more open access groups
Targeted work with highest referring GP clusters

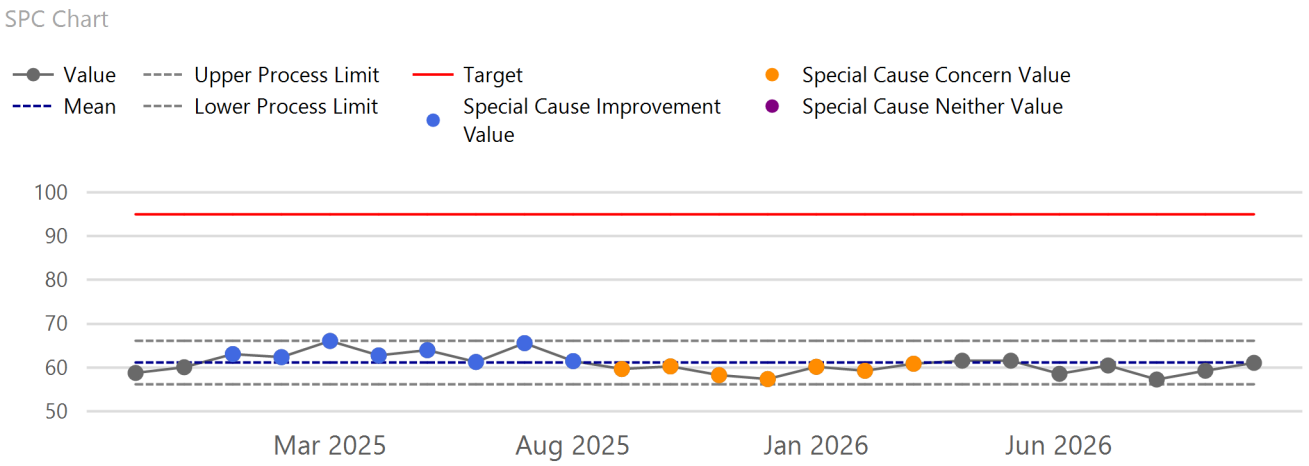
Concerns

Rise in long term sickness absence in PMHSS

Metric ID: 10000023

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

Latest Month	Value	Target	Assurance	Variation	Metric Owner
October 2026	58.8	95	F		Chief Operating Officer



Narrative

No meaningful changes through the year but reduced compliance noted during periods of operational pressures

Actions and Owners

Continued maximisation of MSDEC activity including acute physician pull from ambulatory directly into SDEC.
Development of SPoA, Safe@Home now incorporated to support alternative to EU attendances.
Implementation of 'Prism' flow recommendations.
Actions and performance metrics monitored through UEC Programme Board.

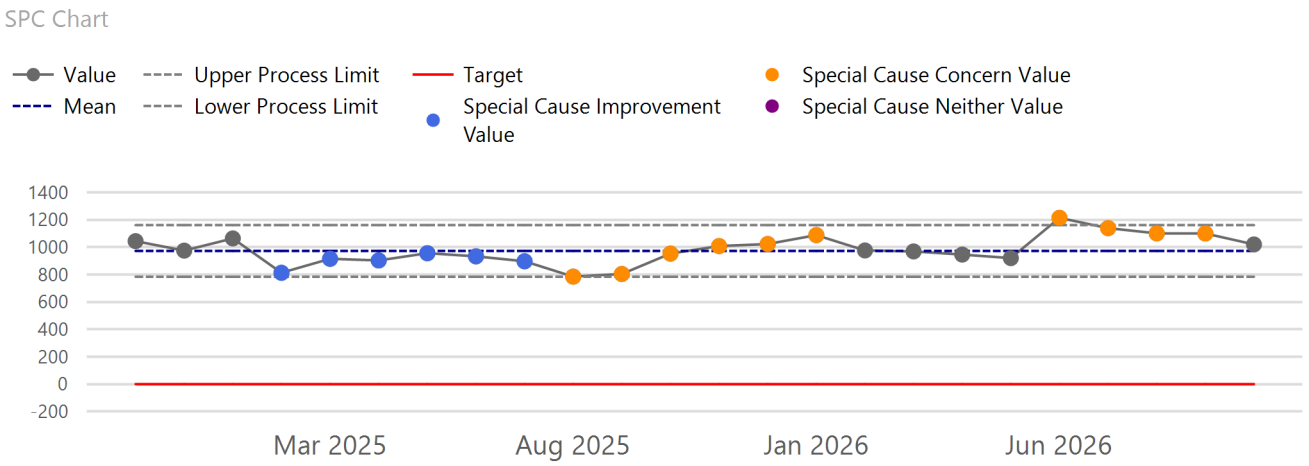
Concerns

No Health Board is meeting this standard

Metric ID: 10000024

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

Latest Month	Value	Target	Assurance	Variation	Metric Owner
October 2026	1044	0	F		Chief Operating Officer



Narrative

No meaningful changes through the year but increases noted during periods of operational pressures through Q2 and Q3. We are routinely reporting over 900 12-hour breaches each month

Actions and Owners

Continued maximisation of MSDEC activity including acute physician pull from ambulatory directly into SDEC.
Development of SPoA, Safe@Home now incorporated to support alternative to EU attendances.
Implementation of 'Prism' flow recommendations.
Actions and performance metrics monitored through UEC Programme Board.

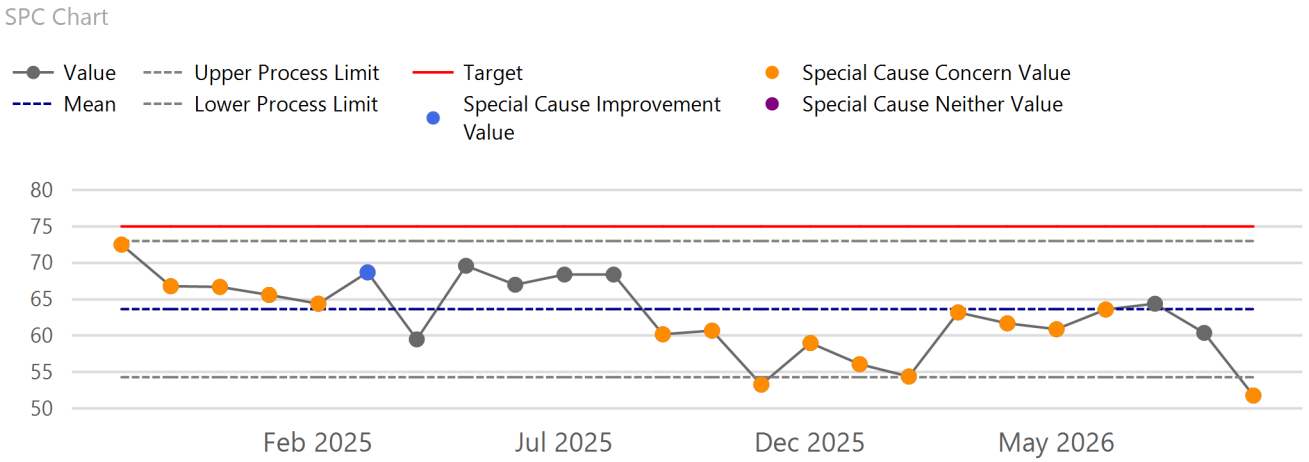
Concerns

Improving performance during periods of high escalation.
We are not meeting our de-escalation criteria

Metric ID: 10000025

Percentage of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	72.5	75	F	L	Chief Operating Officer



Narrative

25% reduction in the 62 day backlog this month with consequent reduction in SCP performance.

We are not meeting the SCP standard of 75%

Actions and Owners

Upcoming actions to reduce and maintain reduced 62 day backlog:
Additional theatre lists for GI surgery.
Recruitment to vacant Breast surgeon post, introduction of consultant mammographers.
Additional consultant capacity in Skin.
Launch of WID-Easy pilot in Gynaecology.
New Urology consultant in Q4

Concerns

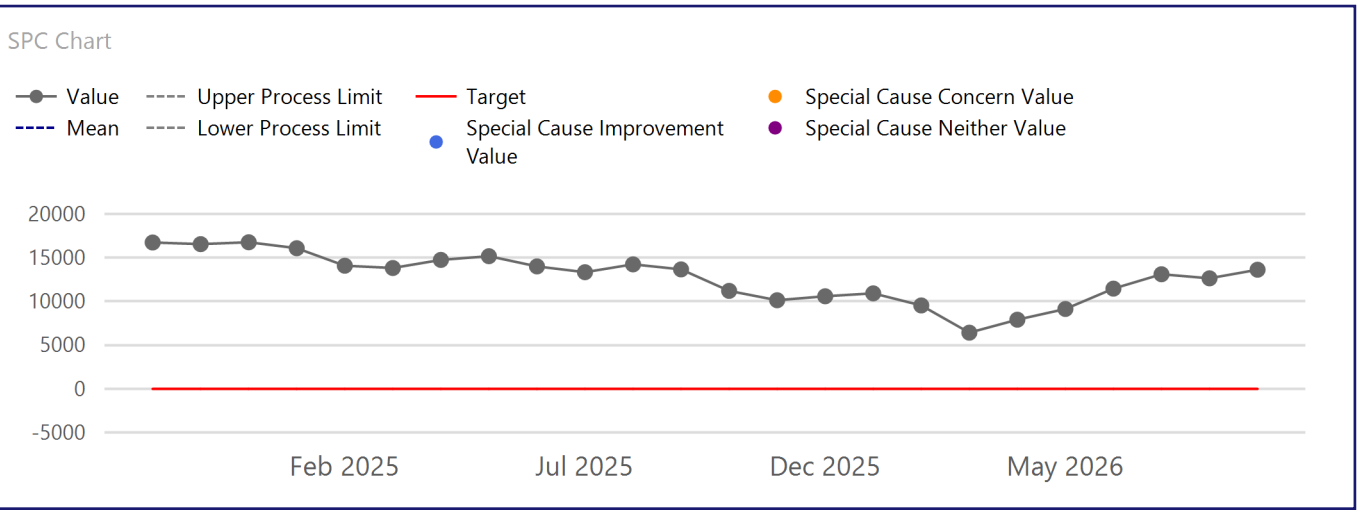
Increase in demand and total waiting list volume

Growth in backlog of patients waiting over 62 days for treatment, reduction seen in September

Sustainable capacity concerns in Upper GI, Urology and Skin

Metric ID: 10000026 Number of patients waiting more than 8 weeks for a specified diagnostic

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	16744	0	F		Chief Operating Officer



Narrative

Significant reduction in 8 week waits through 25/26, driven by improvements in Endoscopy and Radiology, despite increased demand as a result of the national outpatient insourcing programme. Cardiac imaging waits have increased as a result of the insourcing work, but the service have secured insourcing capacity to mitigate this. The 8 week position has increased since March driven by Cardiac imaging, radiology and Endoscopy

Actions and Owners

Non-recurrent insourcing to support Cardiology

Endoscopy - insourcing secured to deliver cancer workload, capacity can be given to improve 8 week position. Llantrisant Health Park will provide recurrent capacity

Short term outsourcing and insourcing to support radiology position

An action plan is being developed with NHSP&I colleagues to secure investment for further diagnostic capacity

Concerns

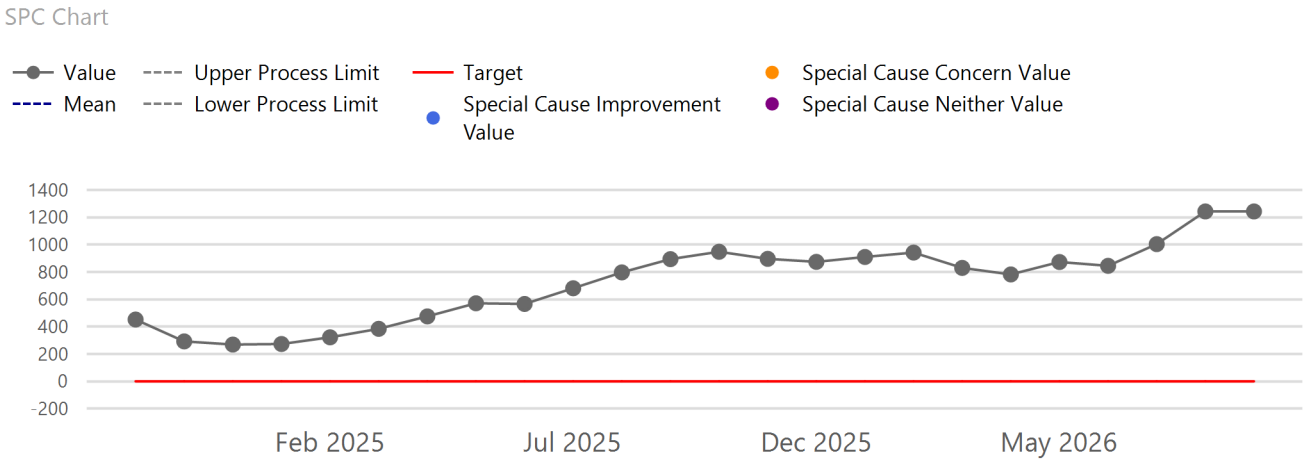
Endoscopy and Radiology capacity

We are consistently not meeting this de-escalation criteria

Metric ID: 10000028

Number of patients (all ages) waiting more than 14 weeks for a specified therapy

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	452	0	F		Chief Operating Officer



Narrative

Total number of patients waiting over 14 weeks has fluctuated, breaches are clustered in Dietetics and Occupational Therapy. Overall c90% of patients are waiting less than 14 weeks for Therapy and we are consistently meeting our de-escalation requirement

Actions and Owners

Text reminders have been rolled out to drive down DNA/CAN rates

Implementation of See on Symptoms (SOS) and Patient Initiated Follow-Up (PIFU) pathways. This has been shown to reduce DNAs and allows FU capacity to be used for new patients

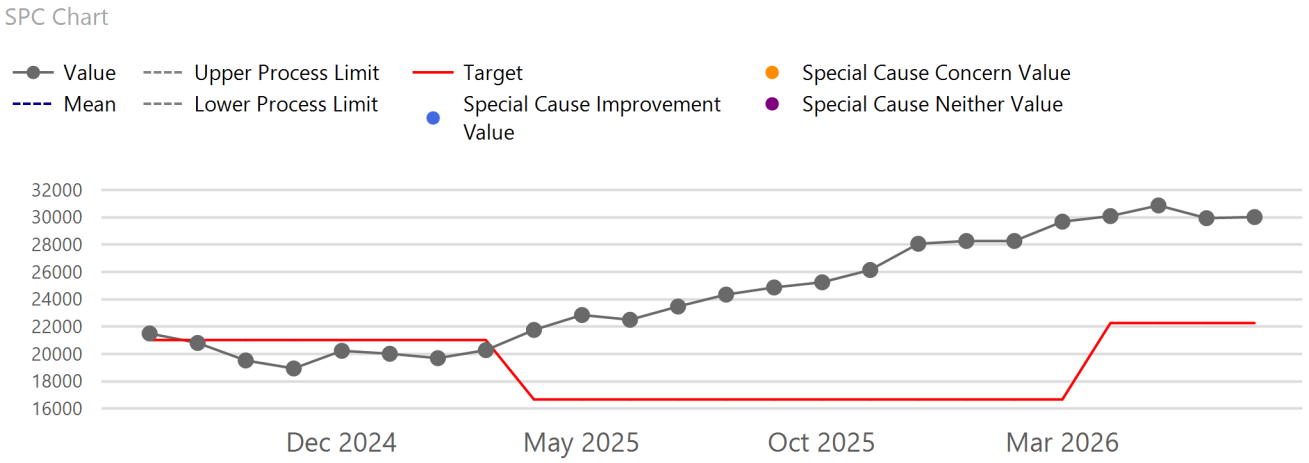
Concerns

Capacity shortfall in Dietetics and OT

Metric ID: 10000031

Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	21500	21015	F		Chief Operating Officer



Narrative

Number of delays increased through 25/26, but has remained steady this year

Actions and Owners

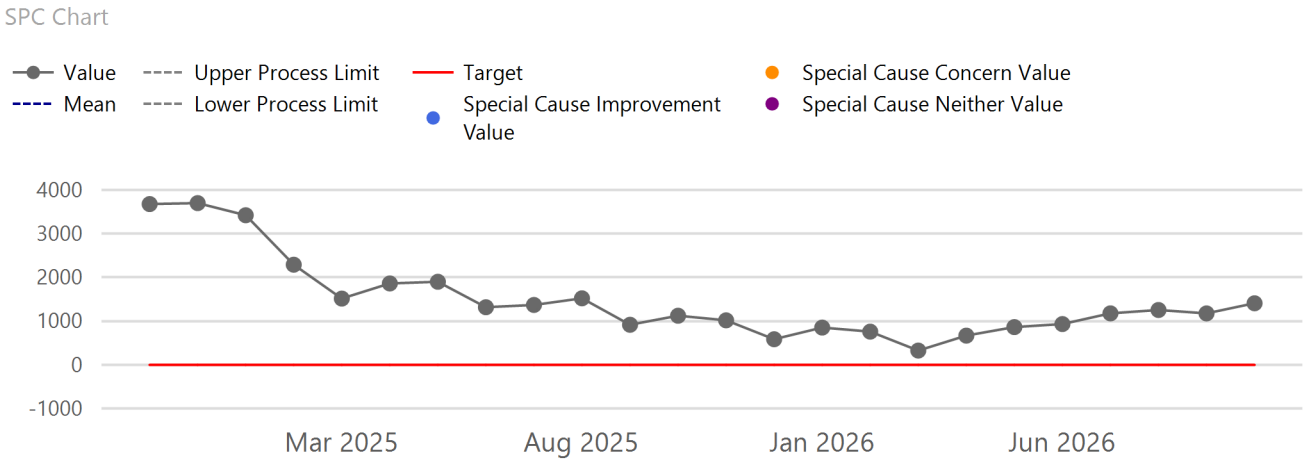
Conversion of unbooked, long waiting follow-ups to SOS/PIFU pathways in selected specialties. This will allow those patients needing follow-up to access an appointment in a timely manor through the see-on-symptoms and patient-initiated follow-up models

Concerns

Risks within follow-up cycle

Metric ID: 10000032 Number of patients waiting more than 104 weeks for referral to treatment

Latest Month	Value	Target	Assurance	Variation	Metric Owner
October 2026	3678	0	F		Chief Operating Officer



Narrative

The number of 2-year waits reduced significantly through 25/26 - additional activity funded non-recurrently. March 2026 saw 2-year waits reduce to their lowest level since April 2021 and the elimination of 3-year waits. The number of patients waiting 2-years for treatment has increased since April, driven mainly by Dermatology, General Surgery and Orthopaedics

Actions and Owners

In line with the most recent correspondence from Welsh Government regarding funding for planned care recovery, we have developed plans both internally and with regional partners to eliminate 2-years waits in as many specialties as possible across the region. These have been shared with Committee and Board.
Increased focus on productivity and efficiency, through clinical board level and Executive chaired Productivity and Efficiency Board.

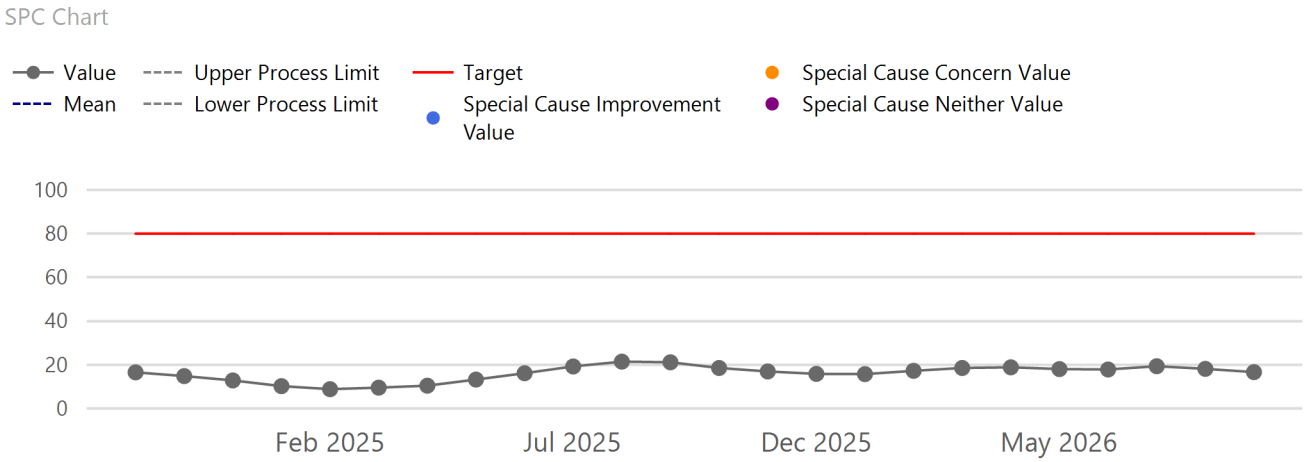
Concerns

Unable to meet required reductions without additional activity

Metric ID: 10000034

Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	16.6	80	F		Chief Operating Officer



Narrative

Performance remains consistently under the standard with capacity unable to match increasing demand for assessments. Despite this, a large amount of work has been undertaken over the past 2 years to transform the referral pathway, to reduce waiting times and support children and families waiting for assessment. These actions include:
-Referral pack includes clearer guidance and signposting pathway to support families while they are on the waiting list and reduce the risk of deterioration in the child's presentation
-Holistic approach across the ND pathway from referral. Whole-system approach has been embedded from triage through to full ND assessment - referrals are accepted for general neurodevelopmental concerns, with structured investigation into ASD, ADHD, and potential comorbidities at all stages to avoid repeat referrals.
-Development of an informed pathway for those children that at the time of the referral have already received input from different professionals and present clear features of ND conditions, to avoid to put them in the waitlist. These children will be given an outcome following a direct clinical contact soon after the referral has been processed
-Dedicated assessment pathways for young people aged 17 and over
-Making every contact count - stronger collaboration has been established across all services. A unified observation template has been drafted and is currently being trialled in OT and SALT to ensure consistent identification and recording of ND traits. Promotes seamless cross-referral and co-working between services

Actions and Owners

Non-recurrent money available for this year to manage 3 year waiting times. Additional actions to increase efficiencies and capacity:
Review of Consultant and Practitioner job planning to increase capacity by over 200 appointments/year
Clinical validation and new 'touch base' letters to allow those no longer needing the service to opt-out
Embed under 5s assessment protocol with dedicated SLT case note reviews. Reduced but does not remove requirement for 2nd assessment
Increased digitisation, including digital platforms for assessments and follow-up appointments
Continued engagement with Education

Performance is monitored within the Clinical Board and through the Clinical Board Executive Reviews

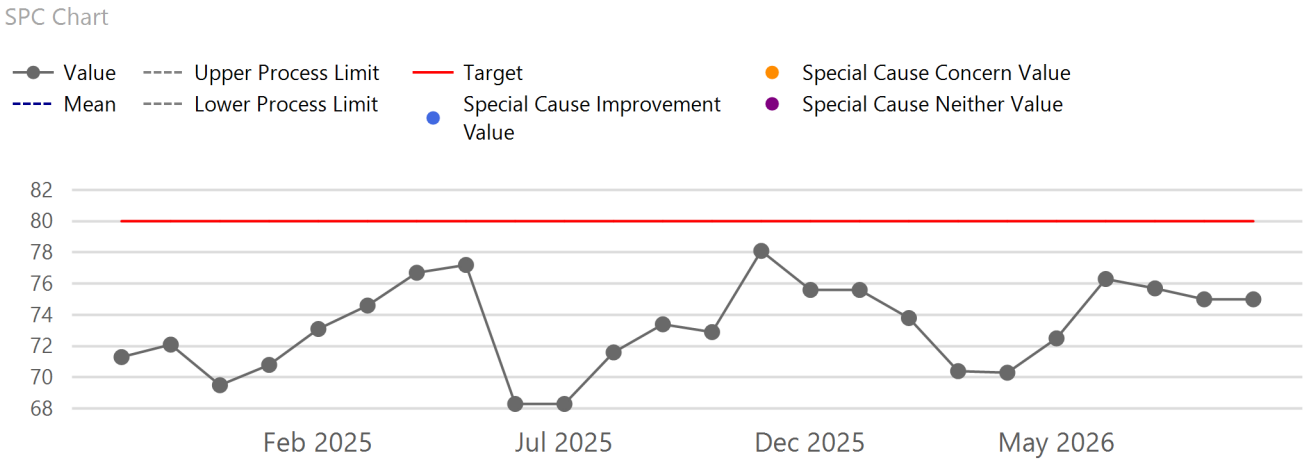
Concerns

Significant capacity shortfall under current model

Metric ID: 10000035

Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	71.3	80	F		Chief Operating Officer



Narrative

Not meeting standard. Second in Wales for compliance against this measure. Current performance impacted by number of waits in Complex PTSD and longer waits for the Traumatic Stress Service

Actions and Owners

Development of OAAT (One at a Time) pilot in CPTD service to reduce waiting times across the service. OAAT focusses on resolving one specific issue per appointment. Monitored through directorate and Clinical Board performance meetings

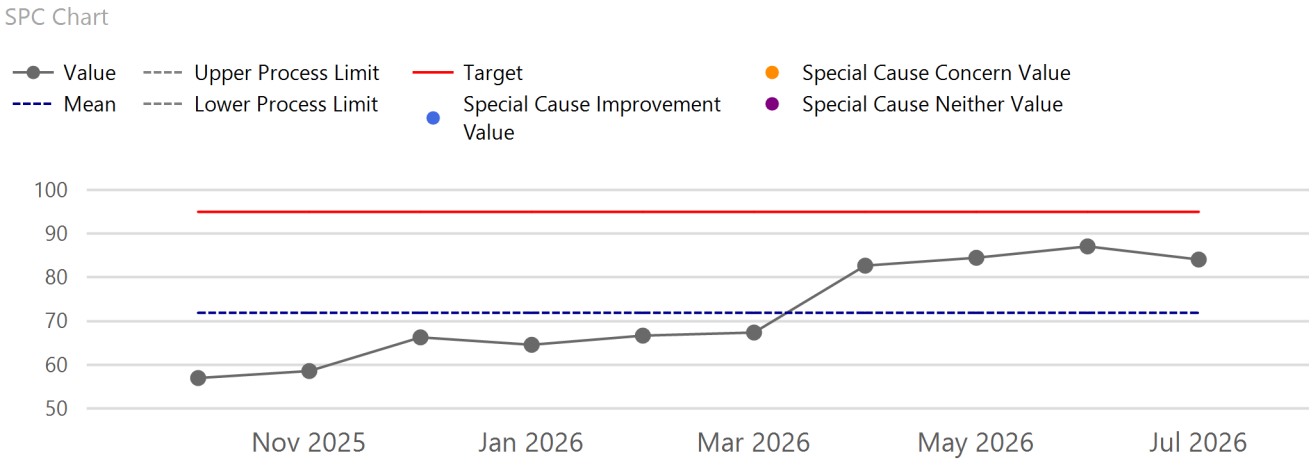
Concerns

Not meeting the standard

Metric ID: 10000041

Percentage of episodes clinically coded within one reporting month post episode discharge end date

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	57	95			Chief Operating Officer



Narrative

Performance remains below the required target; however, sustained improvement has been achieved, with >80% compliance so for in 26/27

Actions and Owners

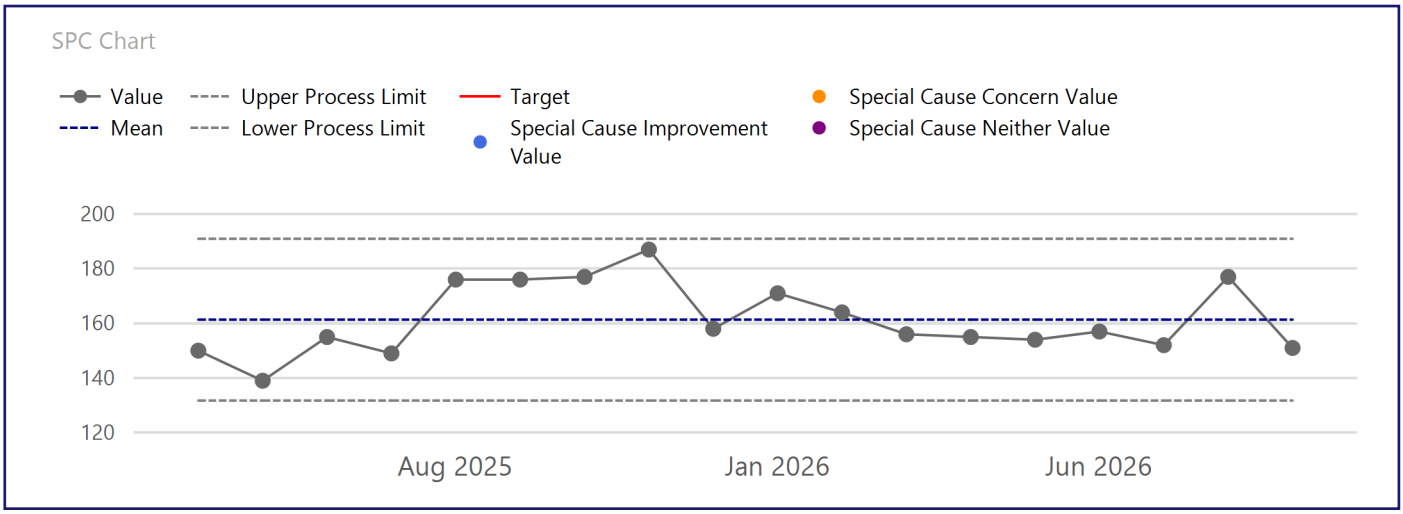
Recent improvements have been supported by enhanced staff retention, productivity improvements across the service, and the strategic deployment of a small number of highly experienced agency coders to supplement the establishment, strengthen skill mix and support ongoing service delivery.
Sustainable Clinical Coding Plan in development

Concerns

In May 2026 Audit Wales issued a follow-up audit report of the service in. Audit Wales recognised improvements in management arrangements, workforce stability and team culture; however, significant risks remain relating to workforce capacity, medical records, clinical engagement, governance, and sustained delivery of national performance standards. Six new recommendations were made and a Sustainable Clinical Coding Plan is now being developed.

Metric ID: 10000043 Number of Pathways of Care delayed discharges

Latest Month	Value	Target	Assurance	Variation	Metric Owner
October 2026	150				Chief Operating Officer



Narrative

No meaningful changes in overall numbers of POCD, although total bed days lost has reduced from the previous month and is reduced from this month last year. The average days delayed in October was 53, compared to 50 in September.

Actions and Owners

Implementation of 'Prism' flow recommendations
Discharge planning on arrival
Focus on Red to Green
Continue top 20 fortnightly review
Review of IDS/IDH workforce
Impact of actions monitored through UEC Programme Board

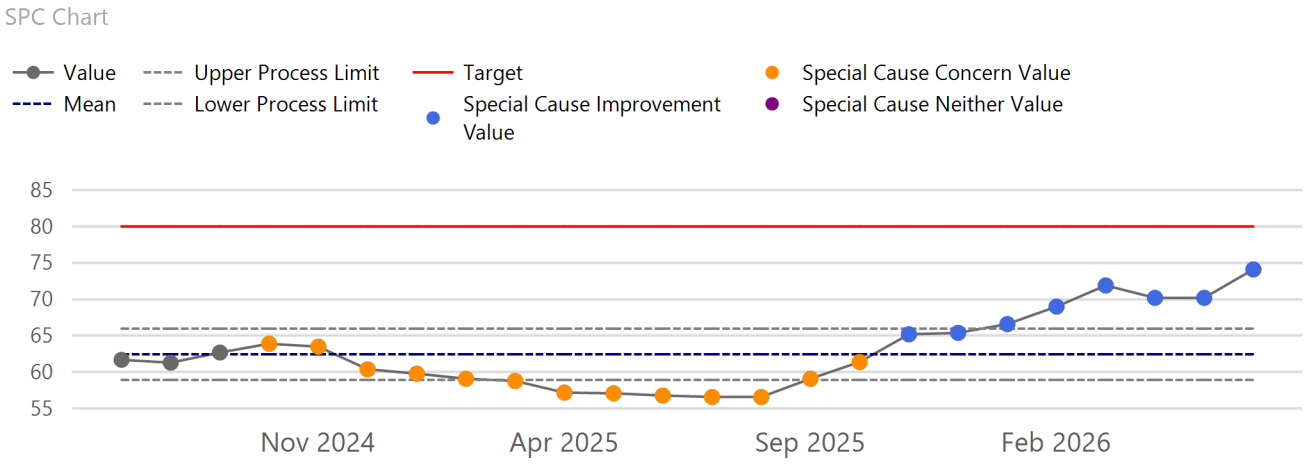
Concerns

Total delays remain higher than our de-escalation criteria

Metric ID: 10000045

Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for adults 18 years and over

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	61.7	80	F	H	Chief Operating Officer



Narrative

Initial rapid process against action plan, recent plateau at c70% for overall compliance, slowly increasing in Q2. The majority of teams are meeting the standard - actions are focussed on 2 CMHTs to improve their performance from c65%

Actions and Owners

Review and redistribute CTPs across all specialties within the teams.
Monitored through newly developed Power BI dashboard (weekly meetings). Monthly Directorate reviews and monthly Touchpoint with NHSP&I colleagues

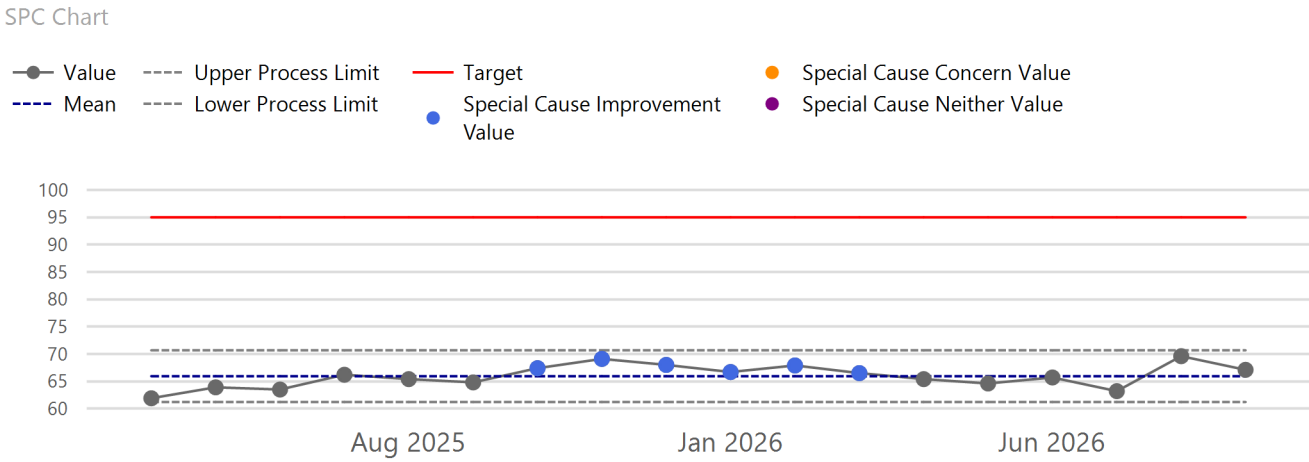
Concerns

Uneven distribution of incomplete CTPs leading to bottlenecks in completion

Metric ID: 10000051

Percentage of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	61.9	95	F		Chief Operating Officer



Narrative

Consistent performance but not always meeting de-escalation requirement. The R1 cohort is predominantly made up of Glaucoma and Medical Retina Patients. We have gone live with our Glaucoma Diagnostic Unit which will allow us to see all our R1 Glaucoma patients in a timely manner.

Actions and Owners

Progressing business case to increase capacity for Medical Retina patients.

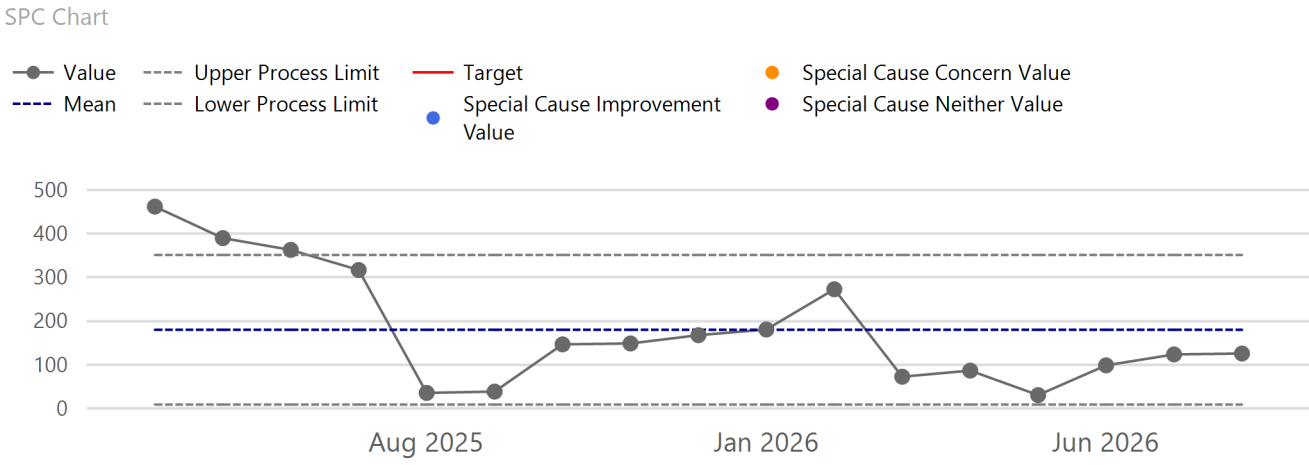
Working with Primary Care on pathway for Diabetic patients to reduce lower grade referrals and free capacity to see urgent patients in a more timely manner

Concerns

Not consistently meeting de-escalation requirement

Metric ID: 10000052 Number of ambulance patient handovers over one hour

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	462				Chief Operating Officer



Narrative

Old measure - replaced with 45 minute handovers

Actions and Owners

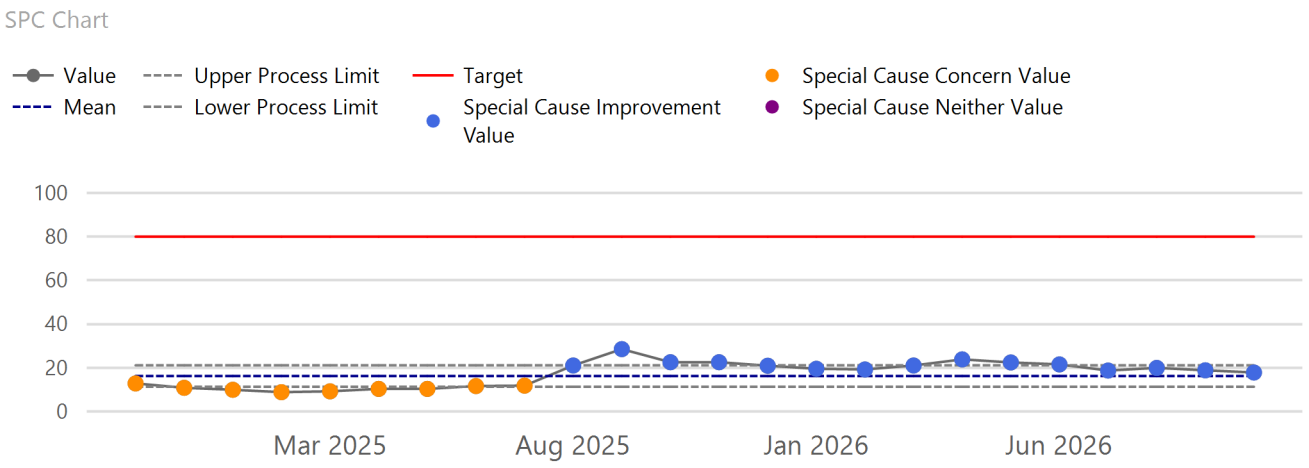
Old measure - replaced with 45 minute handovers

Concerns

Old measure - replaced with 45 minute handovers

Metric ID: 10000053 Percentage of ambulance patient handovers within 15 minutes

Latest Month	Value	Target	Assurance	Variation	Metric Owner
October 2026	12.9	80	F	H	Chief Operating Officer



Narrative

No meaningful change - current operational priority is the 45-minute handover in line with the national requirements

Actions and Owners

Suite of actions to support EU and flow:
Update and refresh of acute referral policy
Escalation triggers moved to 15 and 30 minutes
ACU desk to coordinate timely clinical responses
Acute physician pull model from ambulatory areas direct to Medical SDEC
Phase 1 of acute remodel - frailty assessment
Actions and performance metrics monitored through UEC Programme Board

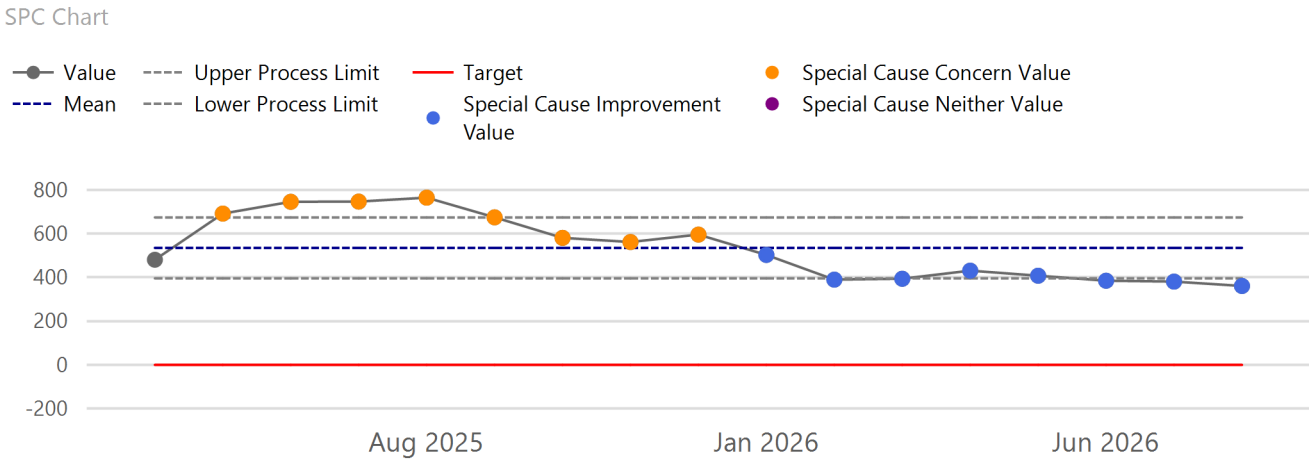
Concerns

Maintaining ambulance performance during periods of high escalation

Metric ID: 10000058

Number of children waiting more than 6 weeks for all audiology pathways (to include new assessment and intervention pathways)

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	481	0	F	L	Chief Operating Officer



Narrative

We have seen an increase in the audiology waiting list through the last year driven by an increase in demand. 14 week waits have increased as capacity within the service is unable to match the increase. To mitigate some of this demand some staff time has been converted from the adult to the paediatric service. Clinical triage of referrals ensures urgent cases are identified and booked directly into the appropriate clinic

Actions and Owners

Service are developing a text reminder service to reduce DNAs and validate patients who no longer need an appointment

3 audiologist posts recruited - starts dates in Q2 and Q3 - providing additional capacity

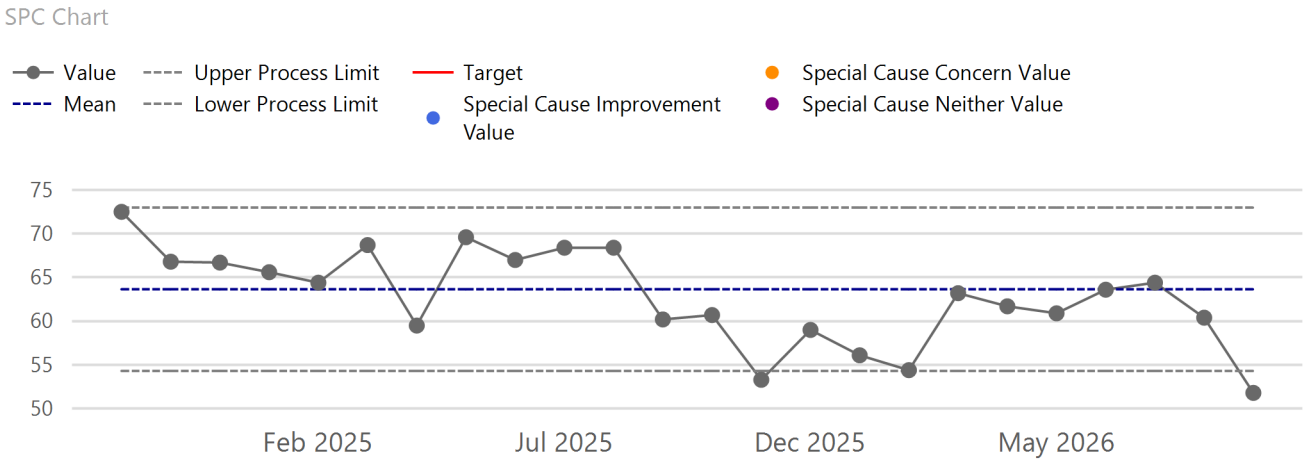
Concerns

Increasing demand and insufficient capacity to meet the waiting time standard

Metric ID: 10000113

% of patients starting first definitive cancer treatment within 62 days from point of suspicion

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	72.5				Chief Operating Officer



Narrative

25% reduction in the 62 day backlog this month with consequent reduction in SCP performance.

We are not meeting the SCP standard of 75%

Actions and Owners

Upcoming actions to reduce and maintain reduced 62 day backlog:
Additional theatre lists for GI surgery.
Recruitment to vacant Breast surgeon post, introduction of consultant mammographers.
Additional consultant capacity in Skin.
Launch of WID-Easy pilot in Gynaecology.
New Urology consultant in Q4

Concerns

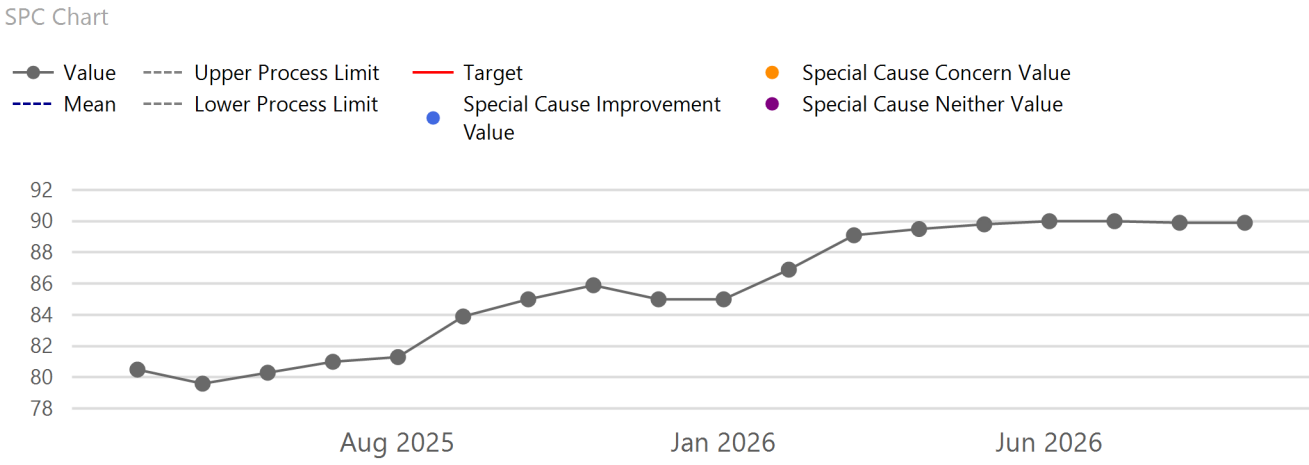
Increase in demand and total waiting list volume

Growth in backlog of patients waiting over 62 days for treatment, reduction seen in September

Sustainable capacity concerns in Upper GI, Urology and Skin

Metric ID: 10000114 100% of open outpatient pathways to be waiting less than 52 weeks

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	80.5				Chief Operating Officer



Narrative

Significant reduction in the volume of long waiting outpatients through last year as a result of the National and Local outpatient insourcing work. An additional 22k appointments were delivered through the national scheme, with a further 9k through C&V schemes. This activity ceased in March 2026 and we have maintained this improved position

Actions and Owners

Outpatient improvement summit in July 2026.
From Q3 - overbooking of outpatient clinics to mitigate the impact of patient DNAs.

Focus on use of SOS/PIFU to free up follow-up capacity for new patients

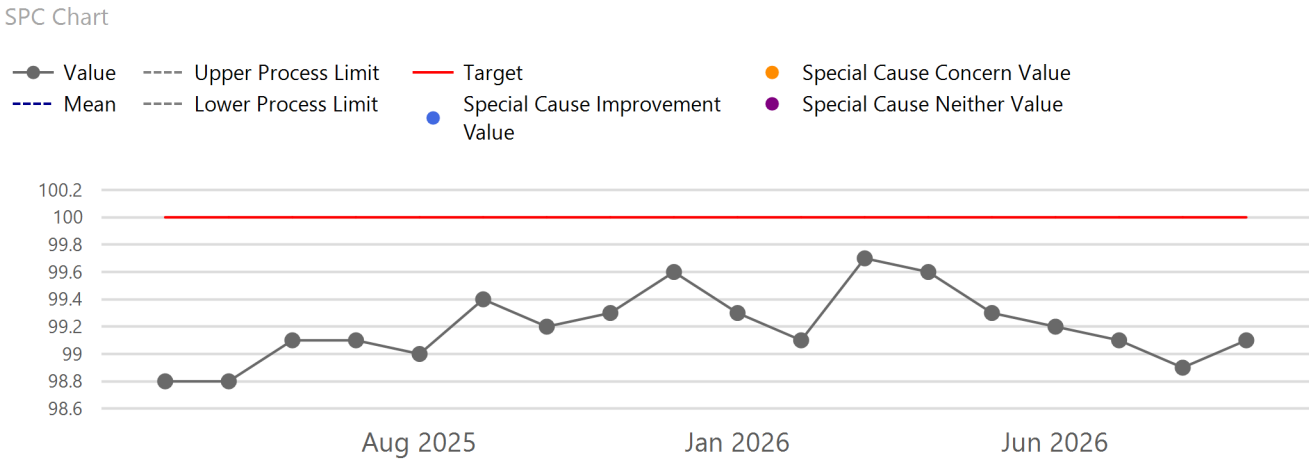
Actions and performance monitored through the newly establish Productivity and Efficiency Board

Concerns

Increase in the number of breaches in some specialties without additional activity

Metric ID: 10000115 100% of open pathways to be waiting less than 104 weeks

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	98.8	100	F		Chief Operating Officer



Narrative

The number of 2-year waits reduced significantly through 25/26 - additional activity funded non-recurrently. March 2026 saw 2-year waits reduce to their lowest level since April 2021 and the elimination of 3-year waits. The number of patients waiting 2-years for treatment has increased since April, driven mainly by Dermatology, General Surgery and Orthopaedics

Actions and Owners

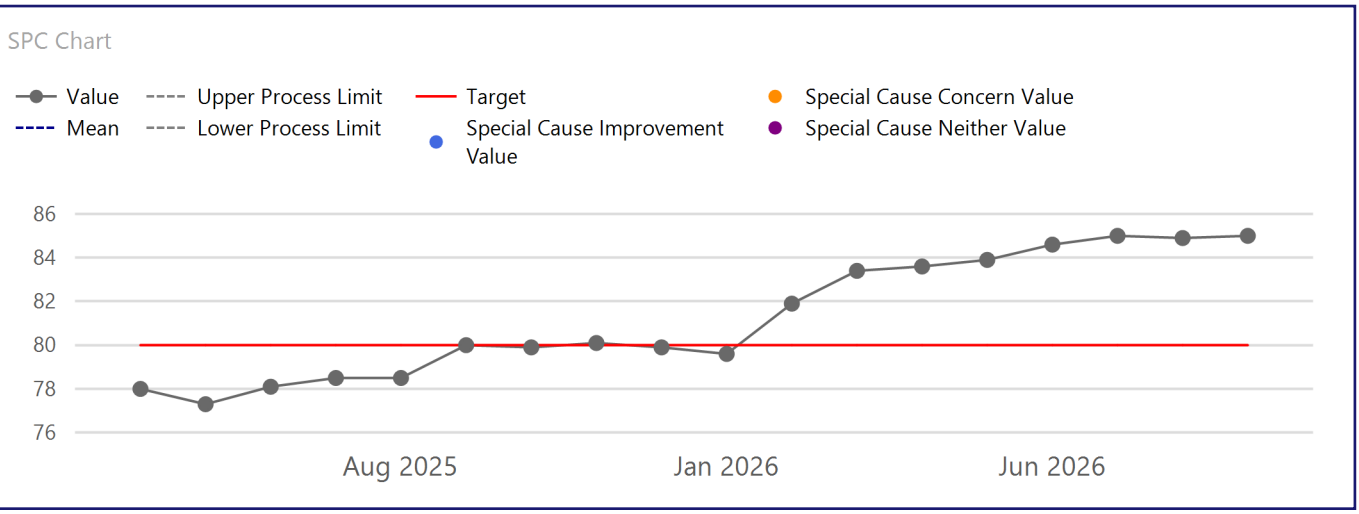
In line with the most recent correspondence from Welsh Government regarding funding for planned care recovery, we have developed plans both internally and with regional partners to eliminate 2-years waits in as many specialties as possible across the region. These have been shared with Committee and Board.
Increased focus on productivity and efficiency, through clinical board level and Executive chaired Productivity and Efficiency Board

Concerns

Unable to meet required reductions without additional activity

Metric ID: 10000116 80% of open pathways to be waiting less than 52?weeks

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	78	80	P		Chief Operating Officer



Narrative

The proportion of open pathways <52 weeks increased last year through a combination of the national outpatient insourcing programmes and additional activity focussed on reducing 2 and 3-year waits for treatment. This work was consolidated with work on referral management. We have met the de-escalation standard since February

Actions and Owners

In line with the most recent correspondence from Welsh Government regarding funding for planned care recovery, we have developed plans both internally and with regional partners to eliminate 2-years waits in as many specialties as possible across the region. These have been shared with Committee and Board.
Increased focus on productivity and efficiency, through clinical board level and Executive chaired Productivity and Efficiency Board.

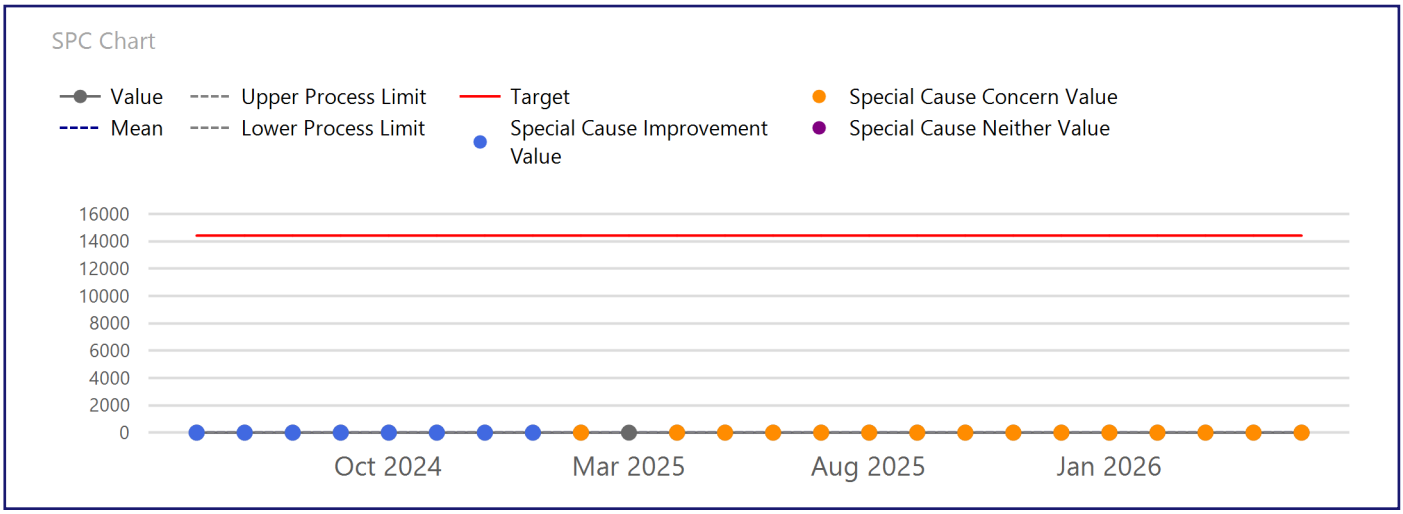
Concerns

Long waits to increase in some specialties without additional activity

Metric ID: 10000117

15% reduction in the number of patients delayed by 100% for their follow up appointment in 3 consecutive months (Based on baseline)

Latest Month	Value	Target	Assurance	Variation	Metric Owner
May 2026	0.161	14415	P	H	Chief Operating Officer



Narrative

Consistently exceeding the target

Actions and Owners

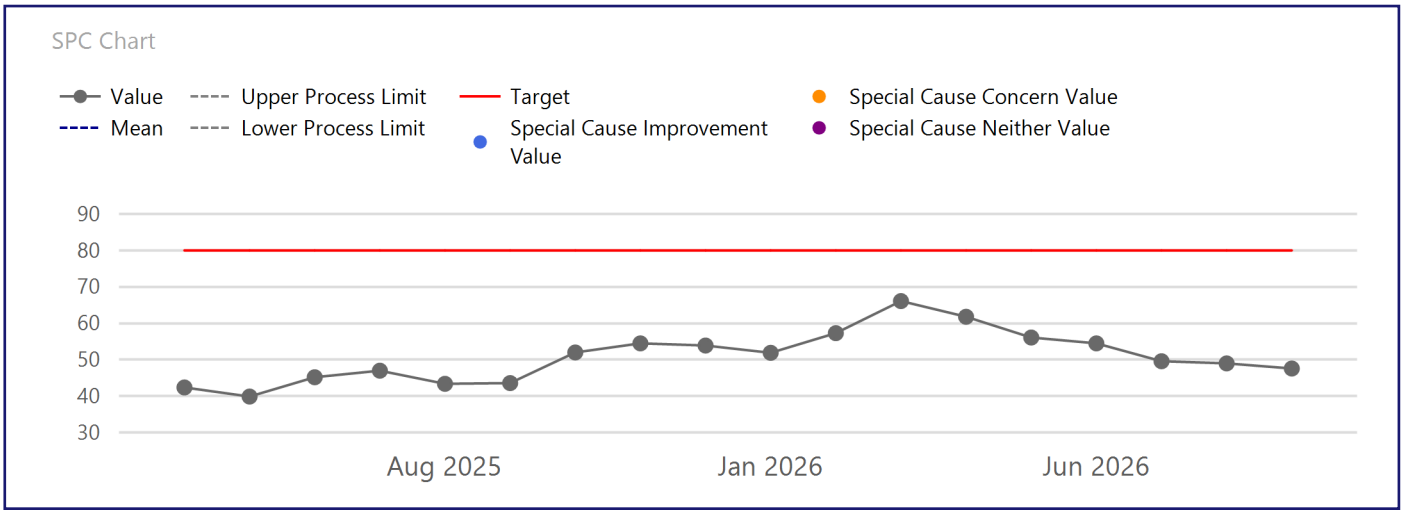
Internal flexibility to ensure sufficient assessments are completed

Concerns

Rise in long term sickness absence in PMHSS

Metric ID: 10000118 80% of patients waiting for a diagnostic test to be waiting less than 8 weeks

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	42.4	80	F		Chief Operating Officer



Narrative

Significant reduction in 8 week waits through 25/26, driven by improvements in Endoscopy and Radiology, despite increased demand as a result of the national outpatient insourcing programme. Cardiac imaging waits have increased as a result of the insourcing work, but the service have secured insourcing capacity to mitigate this. The 8 week position has increased since March driven by Cardiac imaging, NOUS and Endoscopy

Actions and Owners

Non-recurrent insourcing to support Cardiology

Endoscopy - insourcing secured to deliver cancer workload, capacity can be given to improve 8 week position. Llantrisant Health Park will provide recurrent capacity

Short term outsourcing and insourcing to support radiology position

An action plan is being developed with NHSP&I colleagues to secure investment for further diagnostic capacity

Concerns

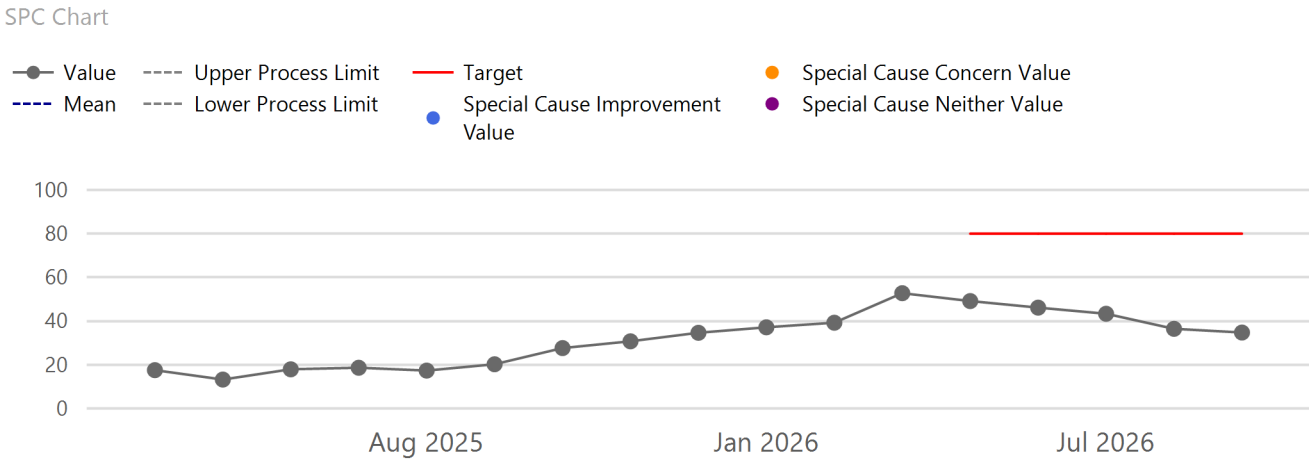
Endoscopy and Radiology capacity

We are consistently not meeting this de-escalation criteria

Metric ID: 10000119

80% of patients waiting for a diagnostic endoscopy to be waiting less than 8 weeks

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	17.6		F		Chief Operating Officer



Narrative

Significant improvement through 25/26 - recurrent capacity issues remain and compliance with the standard is reducing. We are working with colleagues from NHSP&I to develop solutions

Actions and Owners

Insourcing secured to deliver cancer workload, capacity can be given to improve 8 week position. Llantrisant Health Park will provide recurrent capacity

An action plan is being developed with NHSP&I colleagues to secure investment for further diagnostic capacity

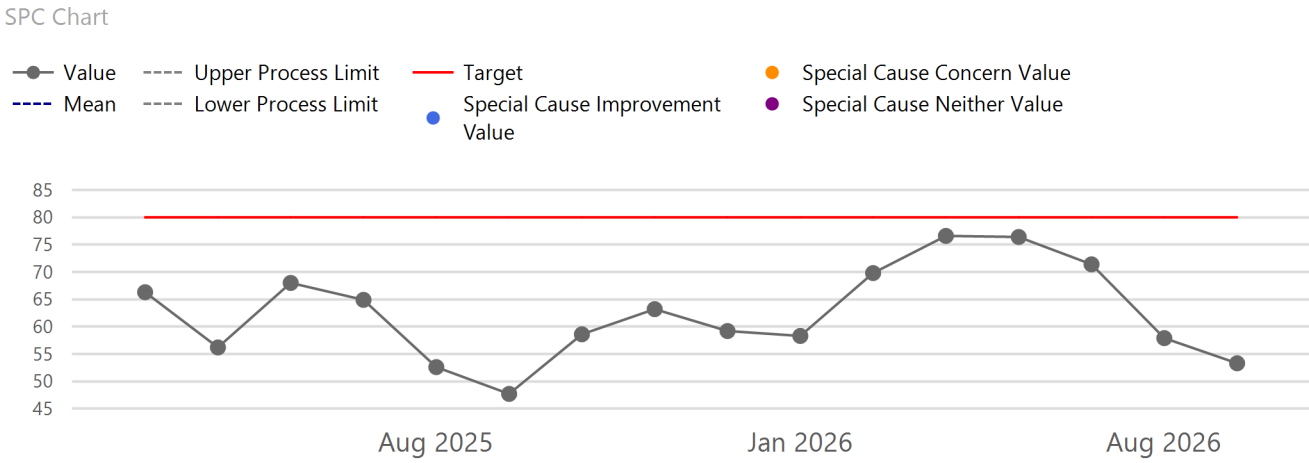
Concerns

Endoscopy capacity

We are consistently not meeting this de-escalation criteria

Metric ID: 10000120 80% of patients waiting for a non-cardiac MRI to be waiting less than 8 weeks

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	66.3	80	F		Chief Operating Officer



Narrative

Improvement noted through Q3 and Q4 25/26 but we are consistently not meeting the standard. Insourcing has been secured to drive down the backlog from Q3 this year

Actions and Owners

Short term insourcing to help recover the backlog of long waits.

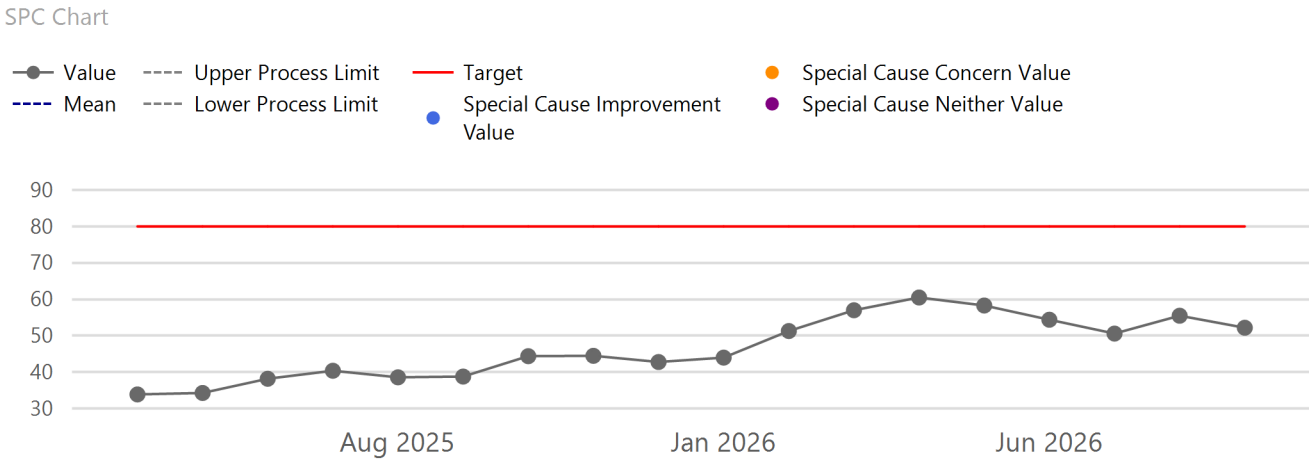
An action plan is being developed with NHSP&I colleagues to secure investment for further diagnostic capacity

Concerns

We are consistently not meeting this de-escalation criteria

Metric ID: 10000121 80% of patients waiting for a NOUS to be waiting less than 8 weeks

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	33.9	80	F		Chief Operating Officer



Narrative

Improvement noted through Q3 and Q4 25/26 but we are consistently not meeting the standard. There was a delay in commencement of the insourcing contract, which did not deliver contracted volumes.

Actions and Owners

Short term support for NOUS with outsourcing, long term plan for advanced sonographer training, build on learning from Swansea Bay UHB model.

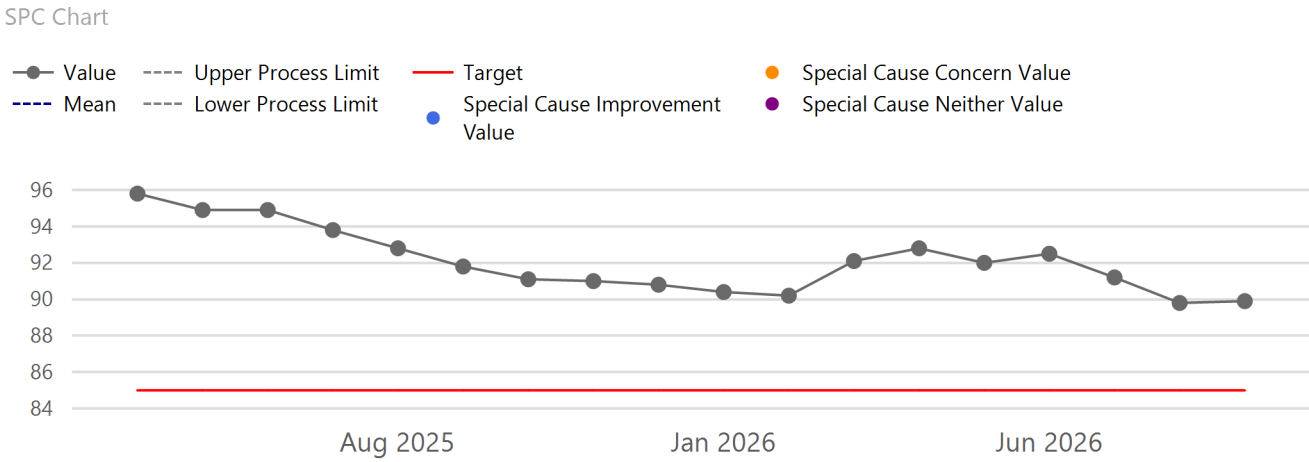
An action plan is being developed with NHSP&I colleagues to secure investment for further diagnostic capacity

Concerns

We are consistently not meeting this de-escalation criteria

Metric ID: 10000122 85% of patients waiting for therapies to be waiting less than 14 weeks

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	95.8	85	P		Chief Operating Officer



Narrative

Total number of patients waiting over 14 weeks has fluctuated, breaches are clustered in Dietetics and Occupational Therapy. Overall c90% of patients are waiting less than 14 weeks for Therapy and we are consistently meeting our de-escalation requirement

Actions and Owners

Text reminders have been rolled out to drive down DNA/CNA rates

Implementation of See on Symptoms (SOS) and Patient Initiated Follow-Up (PIFU) pathways. This has been shown to reduce DNAs and allows FU capacity to be used for new patients

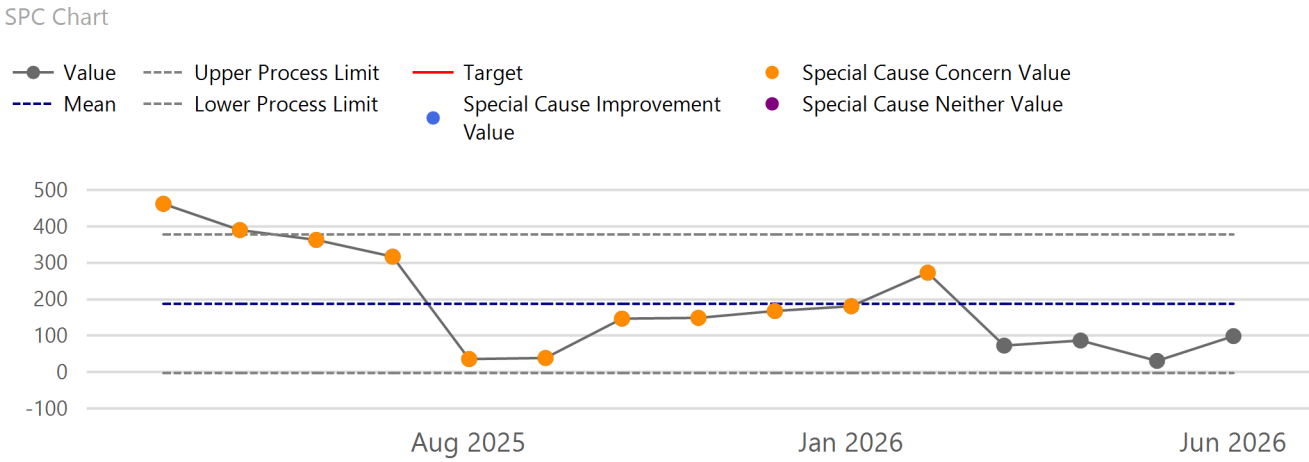
Concerns

Capacity shortfall in Dietetics and OT

Metric ID: 10000123

Continuous reduction of ambulance handovers over an hour of at least 11% in three consecutive months (based on agreed baseline)

Latest Month	Value	Target	Assurance	Variation	Metric Owner
June 2026	462				Chief Operating Officer



Narrative

Our current performance remains improved from last year, but we see fluctuations in line with operational pressures in the EU and across the inpatient and assessment areas. June saw an increase in 1-hour ambulance holds and an increase in the average handover time to 28 minutes from 24 minutes in May. Over half the 1-hour breaches came during the Business Continuity Incident at the end of the month. We are reviewing our data from across the health system over the past 8 weeks to better understand the impact of external and internal pressures.

Actions and Owners

Suite of actions to support EU and flow:
Update and refresh of acute referral policy
Escalation triggers moved to 15 and 30 minutes
ACU desk to coordinate timely clinical responses
Acute physician pull model from ambulatory areas direct to Medical SDEC
Phase 1 of acute remodel - frailty assessment
Actions and performance metrics monitored through UEC Programme Board

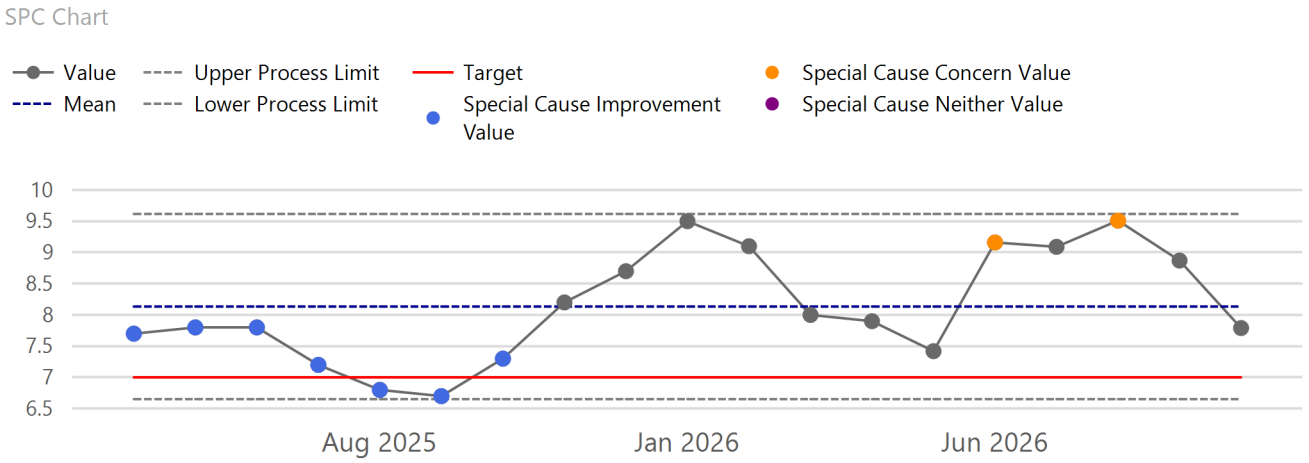
Concerns

Maintaining ambulance performance during periods of high escalation

Metric ID: 10000124

Continuous improvement towards no-more than 7% of patients waiting over 12 hours at each individual site and across the health board

Latest Month	Value	Target	Assurance	Variation	Metric Owner
October 2026	7.7	7			Chief Operating Officer



Narrative

No meaningful changes through the year but increases noted during periods of operational pressures through Q2 and Q3. We are routinely reporting over 900 12-hour breaches each month

Actions and Owners

Continued maximisation of MSDEC activity including acute physician pull from ambulatory directly into SDEC.
Development of SPoA, Safe@Home now incorporated to support alternative to EU attendances.
Implementation of 'Prism' flow recommendations.
Actions and performance metrics monitored through UEC Programme Board.

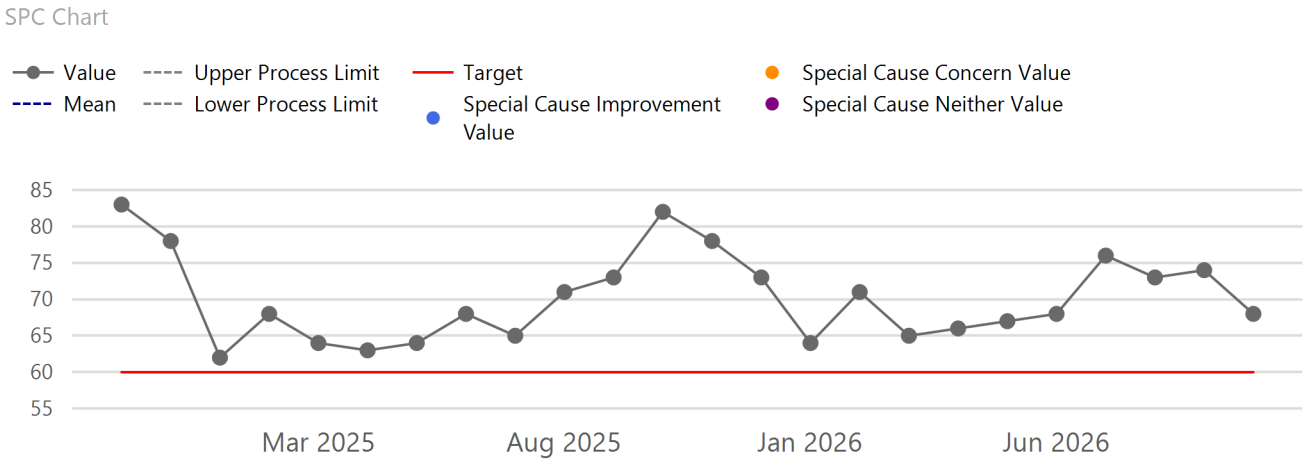
Concerns

Improving performance during periods of high escalation.
We are not meeting our de-escalation criteria

Metric ID: 10000125

Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60-minutes

Latest Month	Value	Target	Assurance	Variation	Metric Owner
October 2026	83	60	F		Chief Operating Officer



Narrative

Deterioration in recent months in line with periods of significant operational pressures

Actions and Owners

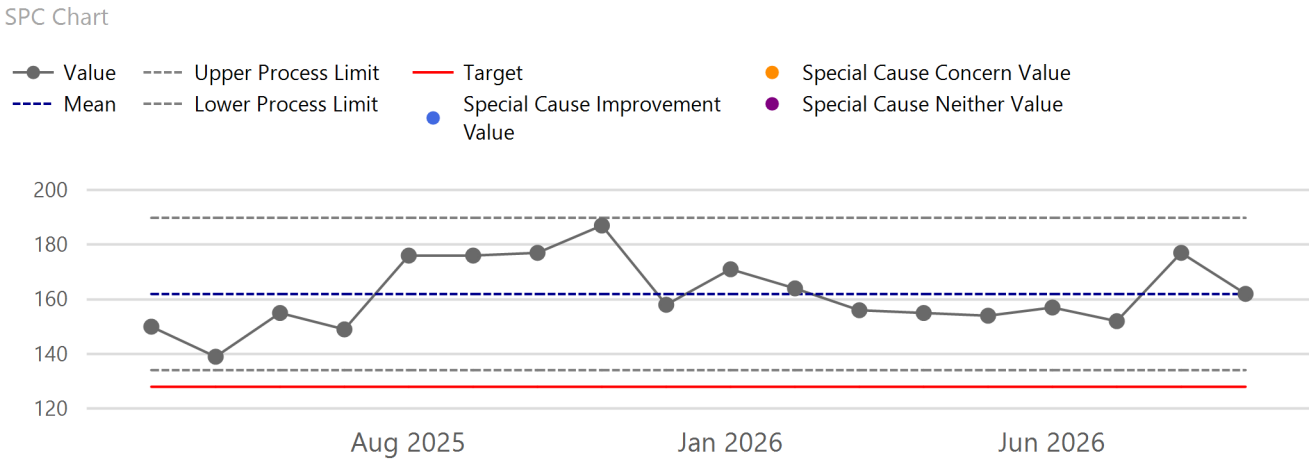
Continued maximisation of MSDEC activity.
Development of SPoA, Safe@Home now incorporated to support alternative to EU attendances.
ACU desk to coordinate timely clinical responses.
Actions and performance metrics monitored through UEC Programme Board.

Concerns

Maintaining performance during periods of high escalation.
We are not meeting our de-escalation criteria

Metric ID: 10000126 Continuous reduction in delayed pathways of 5% (based on agreed baseline)

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	150	128	F		Chief Operating Officer



Narrative

September saw an expected reduction in overall numbers of POCD, although the average days delayed increase to 50. Bed days lost remains reduced from the same month last year

Actions and Owners

Implementation of 'Prism' flow recommendations
Discharge planning on arrival
Focus on Red to Green
Continue top 20 fortnightly review
Review of IDS/IDH workforce
Impact of actions monitored through UEC Programme Board

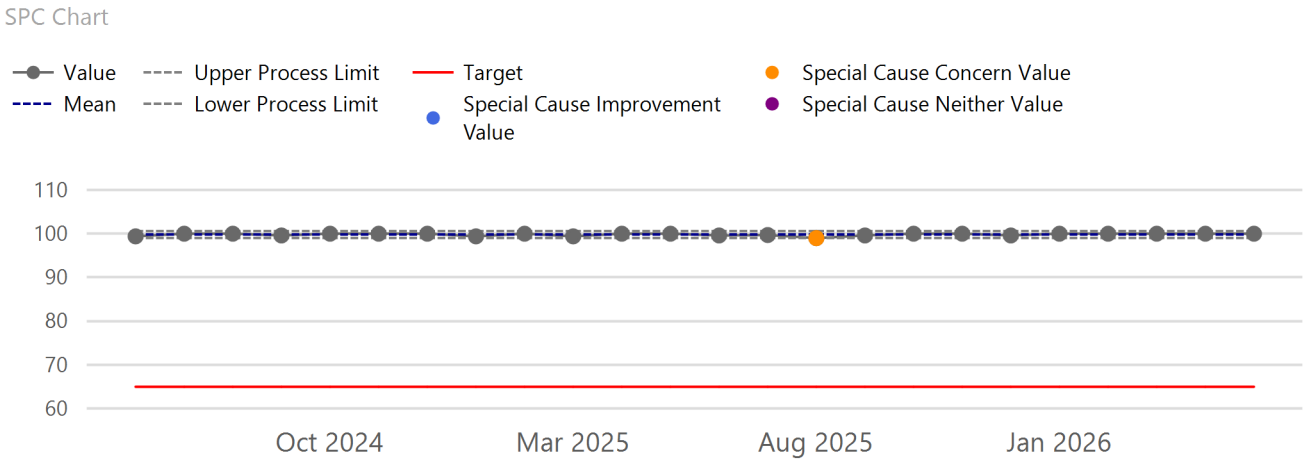
Concerns

Total delays remain higher than our de-escalation criteria

Metric ID: 10000127

65% of therapeutic interventions started within 28 days following an assessment by LPMHSS

Latest Month	Value	Target	Assurance	Variation	Metric Owner
May 2026	99.4	65	P		Chief Operating Officer



Narrative

Consistently exceeding the standard

Actions and Owners

Development of more open access groups
Targeted work with highest referring GP clusters

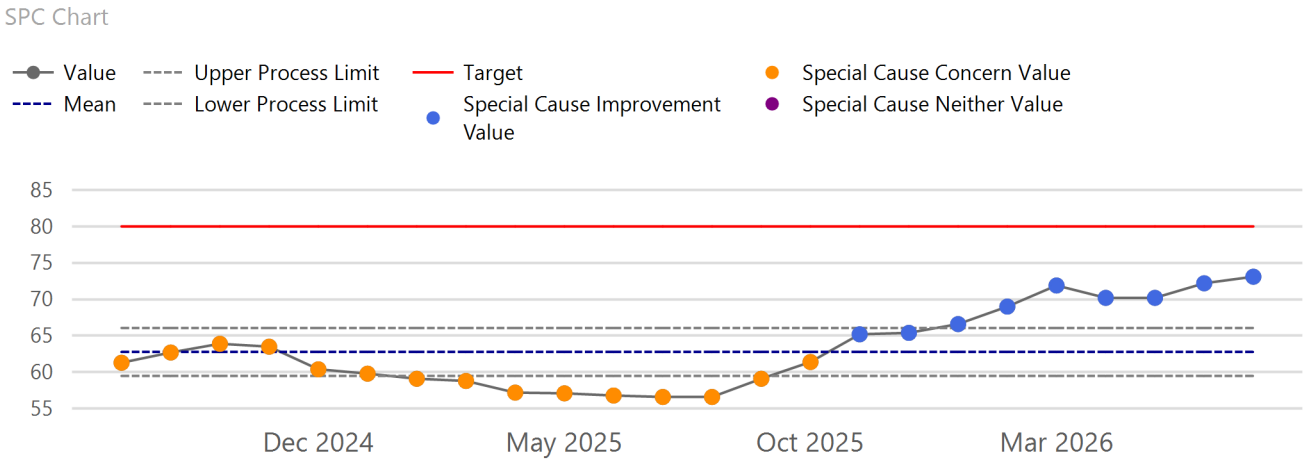
Concerns

Rise in long term sickness absence in PMHSS

Metric ID: 10000128

80% of HB residents in receipt of secondary mental health services who have a valid care and treatment plan

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	61.3	80	F	H	Chief Operating Officer



Narrative

Initial rapid process against action plan, recent plateau at c70% for overall compliance. The majority of teams are meeting the standard - actions are focussed on 2 CMHTs to improve their performance from c65%

Actions and Owners

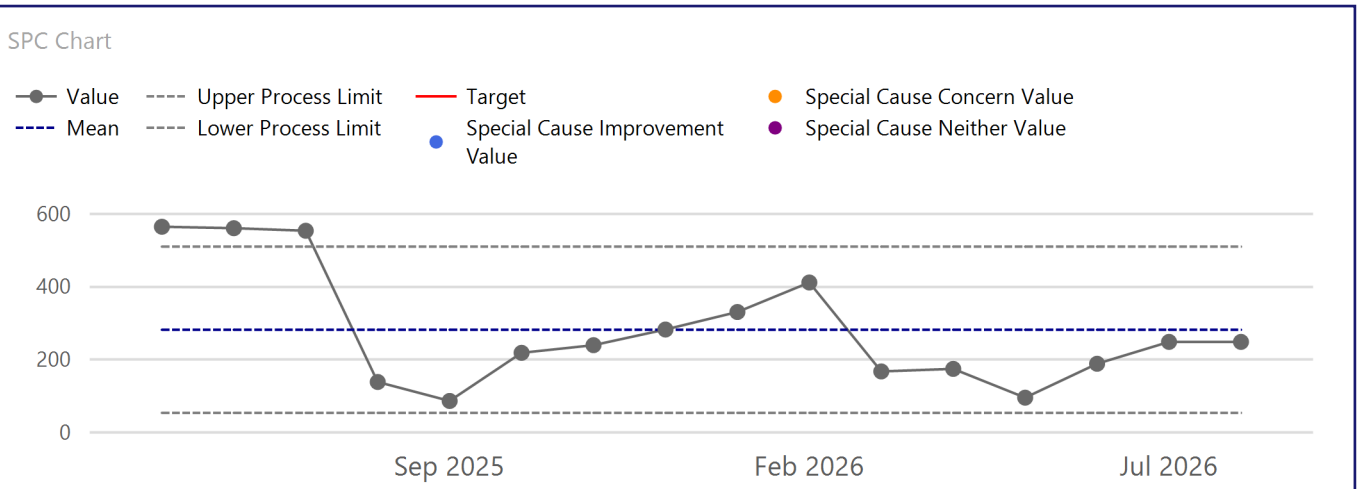
Review and redistribute CTPs across all specialties within the teams.
Monitored through newly developed Power BI dashboard (weekly meetings). Monthly Directorate reviews and monthly Touchpoint with NHSP&I colleagues

Concerns

Uneven distribution of incomplete CTPs leading to bottlenecks in completion

Metric ID: 10000129 45-minute ambulance handover delays

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	565				Chief Operating Officer



Narrative

Our current performance remains improved from last year, but we see fluctuations in line with operational pressures in the EU and across the inpatient and assessment areas. In May 95% of handovers were completed within 45 minutes, this reduced to 88% in June and remained lower at 86% and 85% in July, August and September. We continue to focus on urgent and emergency care as we look to maintain this improvement with our ambition this year to maintain at least 95% of handovers within 45 minutes. All 45 minutes breaches are audited on a weekly basis.

Actions and Owners

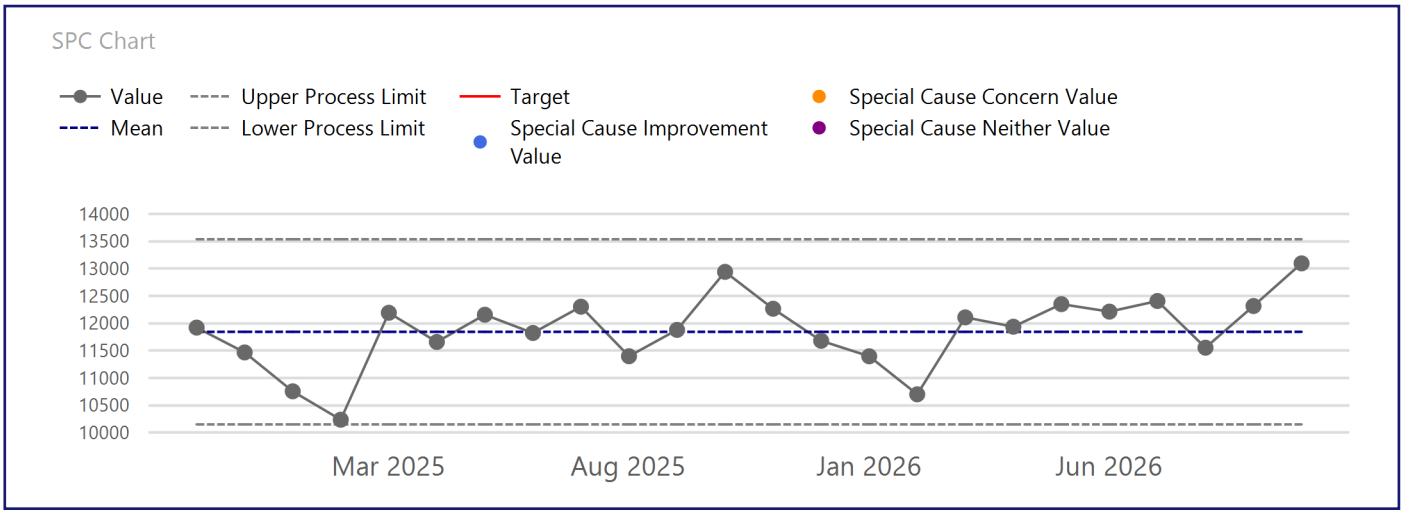
Suite of actions to support EU and flow:
Update and refresh of acute referral policy
Escalation triggers moved to 15 and 30 minutes
ACU desk to coordinate timely clinical responses
Acute physician pull model from ambulatory areas direct to Medical SDEC
Phase 1 of acute remodel - frailty assessment
Actions and performance metrics monitored through UEC Programme Board

Concerns

Maintaining ambulance performance during periods of high escalation

Metric ID: 10000130 Emergency unit attendances

Latest Month	Value	Target	Assurance	Variation	Metric Owner
October 2026	11922				Chief Operating Officer



Narrative

Metric provided for information. The C&V approach for reporting against these measures will be reviewed as part of the next phase of IPR development

Actions and Owners

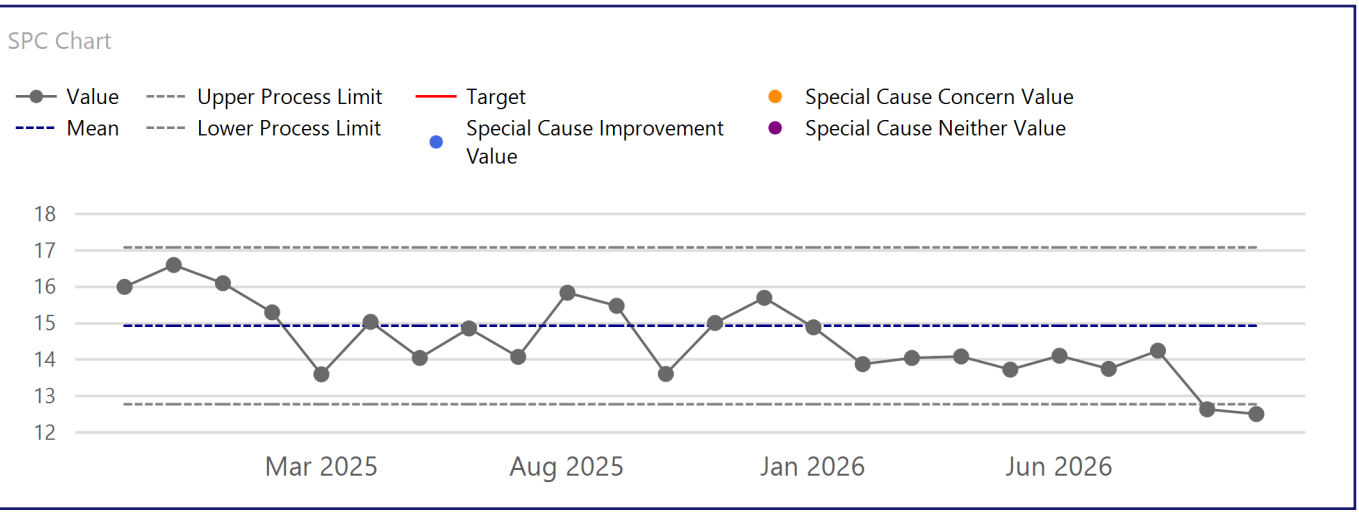
n/a

Concerns

n/a

Metric ID: 10000131 % of EU attendances that results in an admission to hospital

Latest Month	Value	Target	Assurance	Variation	Metric Owner
October 2026	16				Chief Operating Officer



Narrative

Metric provided for information. The C&V approach for reporting against these measures will be reviewed as part of the next phase of IPR development

Actions and Owners

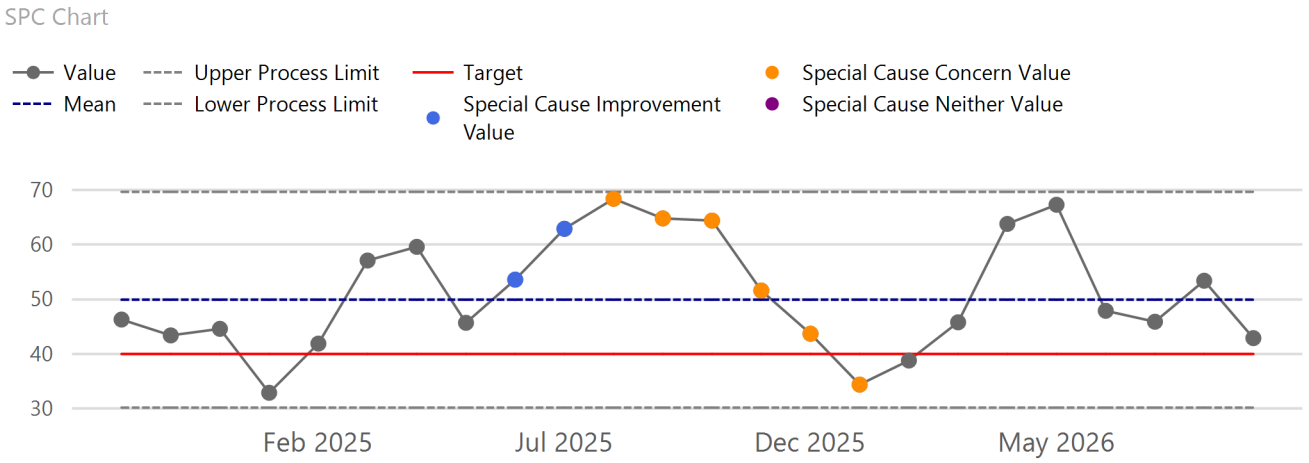
n/a

Concerns

n/a

Metric ID: 10000136 % of stroke admissions within 4 hours of arrival

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	46.3	40			Chief Operating Officer



Narrative

Performance has fluctuated in line with wider operational pressures in Emergency Unit, current performance remains above the all Wales average and SSNAP average, but we continue to review and develop the acute pathway. Compliance with the 4-hour standard reduced in September

Actions and Owners

Progression of new service model, including trialling of new Code Stroke EU pathway from June, review of triage processes, scoping for a new TIA clinic.

Revised breach analysis meeting with new membership across EU, radiology, service and site management

Ongoing QI work with Welsh Ambulance, including move to Prehospital Video Triage this year as part of phase 2 of the All Wales project

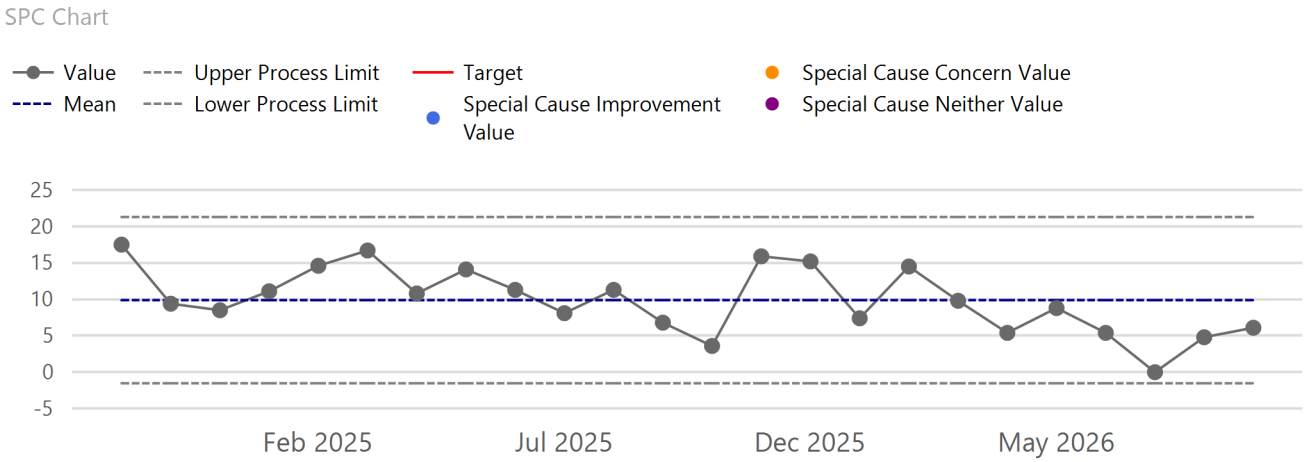
Education plan for all staff involved in stroke pathway being developed

Concerns

Reduced compliance with the new SSNAP standards

Metric ID: 10000137 % of stroke attendances that achieve CT Scan within 20 minutes

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	17.5				Chief Operating Officer



Narrative

Following the launch of the new SNNAP standards, the performance standard for CT scan has changed to 20 minutes. While performance against the old 60 minute standards averages over 50%, performance against the 20 minute standard has fluctuated between 3 and 17%. Performance against this metric is impacted by pressure in EU, periods of downtime for the CT scanner and the volume of self presenting patients who enter EU through triage. Actions relating to WAST, pre-hospital triage and early identification of self presenting patients are particularly pertinent to this measure

Actions and Owners

Progression of new service model, including trialling of new Code Stroke EU pathway from June, review of triage processes, scoping for a new TIA clinic.

Revised breach analysis meeting with new membership across EU, radiology, service and site management

Ongoing QI work with Welsh Ambulance, including move to Prehospital Video Triage this year as part of phase 2 of the All Wales project

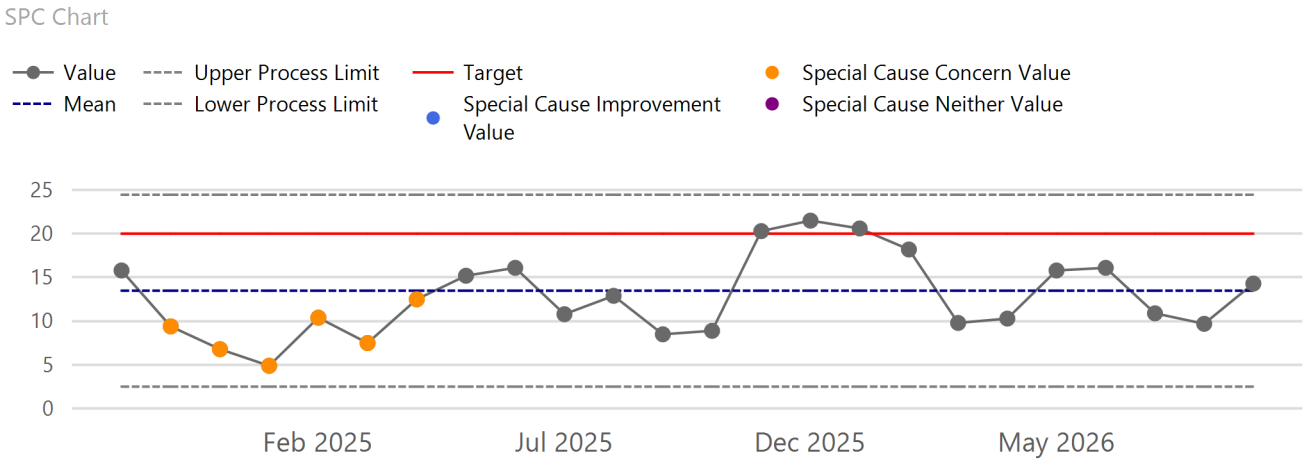
Education plan for all staff involved in stroke pathway being developed

Concerns

Reduced compliance with the new SSNAP standards

Metric ID: 10000139 % of stroke patients who receive thrombolysis

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	15.8	20			Chief Operating Officer



Narrative

Standard of 20% was met in Q3 25/26 but compliance has dropped this year and remains below standard but in-line with the all-Wales and SSNAP average. Focused efforts through the last year, including the use of advanced imaging software and ongoing education have seen a meaningful increase in thrombolysis rates

Actions and Owners

Progression of new service model, including trialling of new Code Stroke EU pathway from June, review of triage processes, scoping for a new TIA clinic.

Revised breach analysis meeting with new membership across EU, radiology, service and site management

Ongoing QI work with Welsh Ambulance, including move to Prehospital Video Triage this year as part of phase 2 of the All Wales project

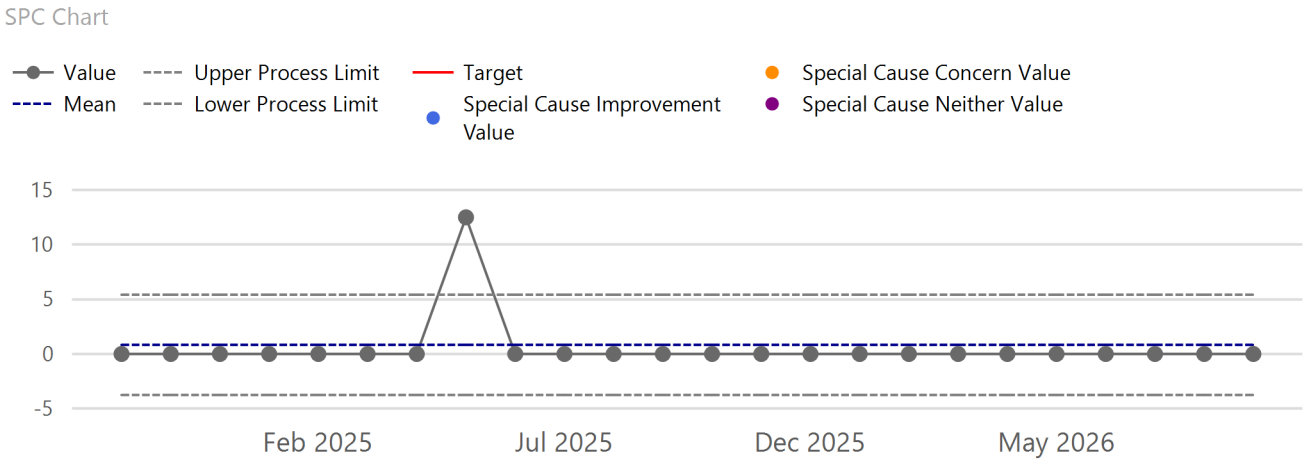
Education plan for all staff involved in stroke pathway being developed

Concerns

Reduced compliance with the new SSNAP standards

Metric ID: 10000140 % of stroke patients who receive thrombolysis within 30 minutes of attendance

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	0				Chief Operating Officer



Narrative

Door to needle thrombolysis treatment times remain a challenge and outside of the 30-minutes standard. All thrombolysis cases are reviewed by the stroke team and delay reasons investigated

Actions and Owners

Progression of new service model, including trialling of new Code Stroke EU pathway from June, review of triage processes, scoping for a new TIA clinic.

Revised breach analysis meeting with new membership across EU, radiology, service and site management

Ongoing QI work with Welsh Ambulance, including move to Prehospital Video Triage this year as part of phase 2 of the All Wales project

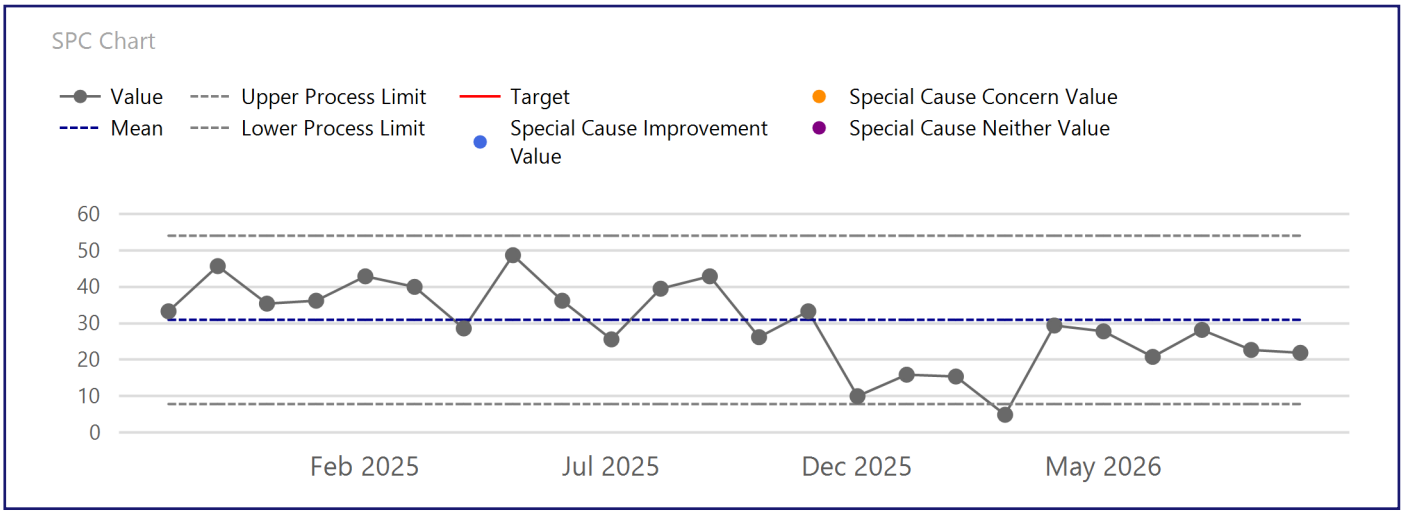
Education plan for all staff involved in stroke pathway being developed

Concerns

Door to needle time remains above standard

Metric ID: 10000142 % of hip fracture admissions within 4 hours of arrival

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	33.3				Chief Operating Officer



Narrative

Recent performance and annualised average remain well above the national average on the National Hip Fracture Database

Actions and Owners

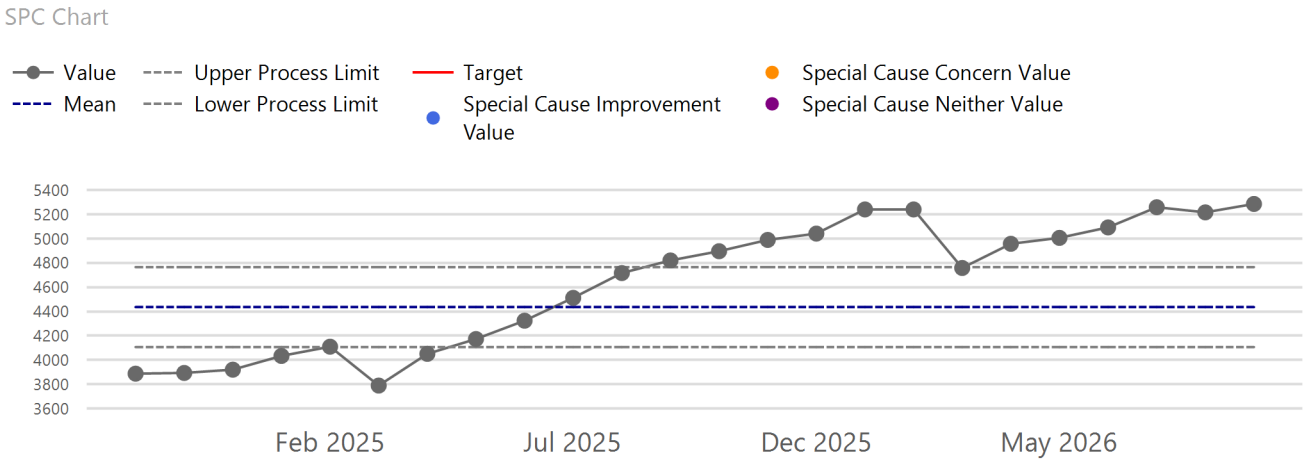
Ringfenced capacity remains
Review into Length of Stay
Morality review through Q&S and this month's Executive reviews

Concerns

Fluctuations in performance

Metric ID: 10000145 Volume of children waiting for neurodevelopment assessment - total

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	3888				Chief Operating Officer



Narrative

Performance remains consistently under the standard with capacity unable to match increasing demand for assessments. Despite this, a large amount of work has been undertaken over the past 2 years to transform the referral pathway, to reduce waiting times and support children and families waiting for assessment. These actions include:
-Referral pack includes clearer guidance and signposting pathway to support families while they are on the waiting list and reduce the risk of deterioration in the child's presentation
-Holistic approach across the ND pathway from referral. Whole-system approach has been embedded from triage through to full ND assessment - referrals are accepted for general neurodevelopmental concerns, with structured investigation into ASD, ADHD, and potential comorbidities at all stages to avoid repeat referrals.
-Development of an informed pathway for those children that at the time of the referral have already received input from different professionals and present clear features of ND conditions, to avoid to put them in the waitlist. These children will be given an outcome following a direct clinical contact soon after the referral has been processed
-Dedicated assessment pathways for young people aged 17 and over
-Making every contact count - stronger collaboration has been established across all services. A unified observation template has been drafted and is currently being trialled in OT and SALT to ensure consistent identification and recording of ND traits. Promotes seamless cross-referral and co-working between services

Actions and Owners

Non-recurrent money available for this year to address the 3 year waits. Additional actions to increase efficiencies and capacity:
Review of Consultant and Practitioner job planning to increase capacity by over 200 appointments/year
Clinical validation and new 'touch base' letters to allow those no longer needing the service to opt-out
Embed under 5s assessment protocol with dedicated SLT case note reviews. Reduced but does not remove requirement for 2nd assessment
Increased digitisation, including digital platforms for assessments and follow-up appointments
Continued engagement with Education

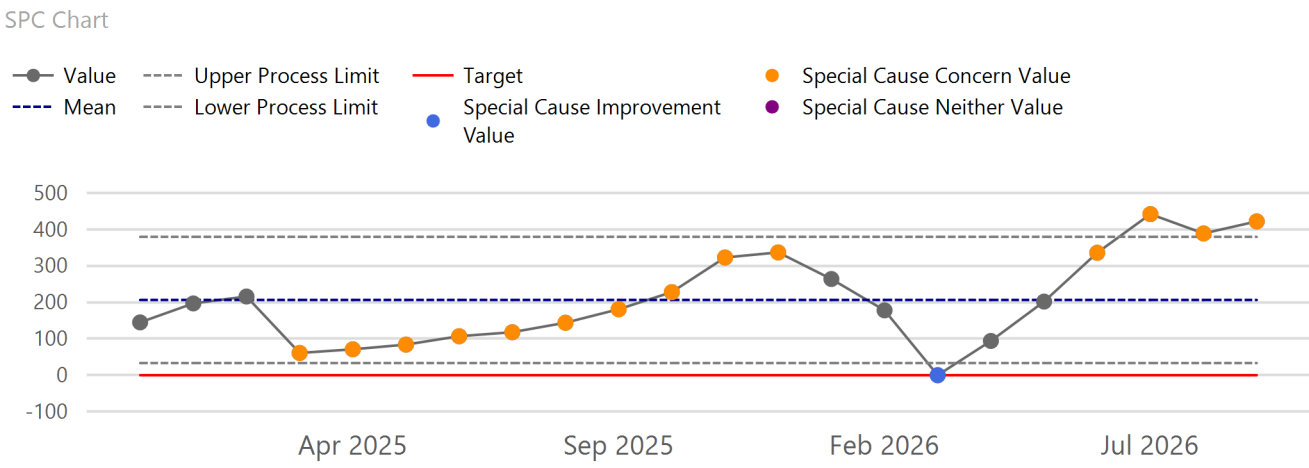
Performance is monitored within the Clinical Board and through the Clinical Board Executive Reviews

Concerns

Significant capacity shortfall under current model

Metric ID: 10000146 Volume of children waiting for neurodevelopment assessment - >156 weeks

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	145	0	F	H	Chief Operating Officer



Narrative

Performance remains consistently under the standard with capacity unable to match increasing demand for assessments. Despite this, a large amount of work has been undertaken over the past 2 years to transform the referral pathway, to reduce waiting times and support children and families waiting for assessment. These actions include:
-Referral pack includes clearer guidance and signposting pathway to support families while they are on the waiting list and reduce the risk of deterioration in the child's presentation
-Holistic approach across the ND pathway from referral. Whole-system approach has been embedded from triage through to full ND assessment - referrals are accepted for general neurodevelopmental concerns, with structured investigation into ASD, ADHD, and potential comorbidities at all stages to avoid repeat referrals.
-Development of an informed pathway for those children that at the time of the referral have already received input from different professionals and present clear features of ND conditions, to avoid to put them in the waitlist. These children will be given an outcome following a direct clinical contact soon after the referral has been processed
-Dedicated assessment pathways for young people aged 17 and over
-Making every contact count - stronger collaboration has been established across all services. A unified observation template has been drafted and is currently being trialled in OT and SALT to ensure consistent identification and recording of ND traits. Promotes seamless cross-referral and co-working between services

Actions and Owners

Non-recurrent money available for this year - currently assessing options for best use of this money within funding constraints. Additional actions to increase efficiencies and capacity:
Review of Consultant and Practitioner job planning to increase capacity by over 200 appointments/year
Clinical validation and new 'touch base' letters to allow those no longer needing the service to opt-out
Embed under 5s assessment protocol with dedicated SLT case note reviews. Reduced but does not remove requirement for 2nd assessment
Increased digitisation, including digital platforms for assessments and follow-up appointments
Continued engagement with Education

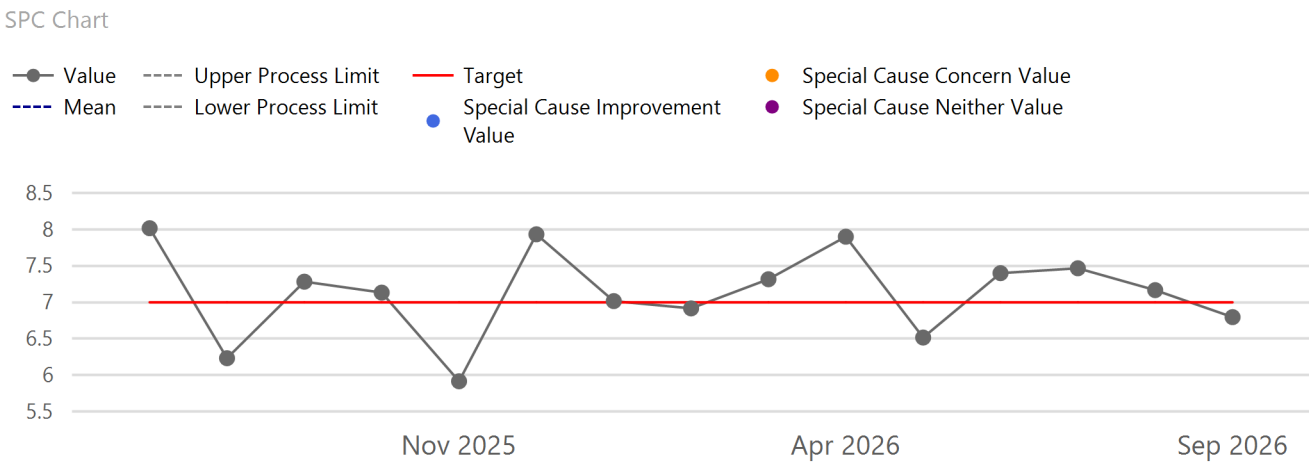
Performance is monitored within the Clinical Board and through the Clinical Board Executive Reviews

Concerns

Significant capacity shortfall under current model

Metric ID: 10000147 Median emergency ambulance response time to purple: arrest category calls

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	8.0167	7	P		Chief Operating Officer



Narrative

This measure is owned by WAST and the national data is currently under review. The C&V approach for reporting against these measures will be reviewed as part of the next phase of IPR development

Actions and Owners

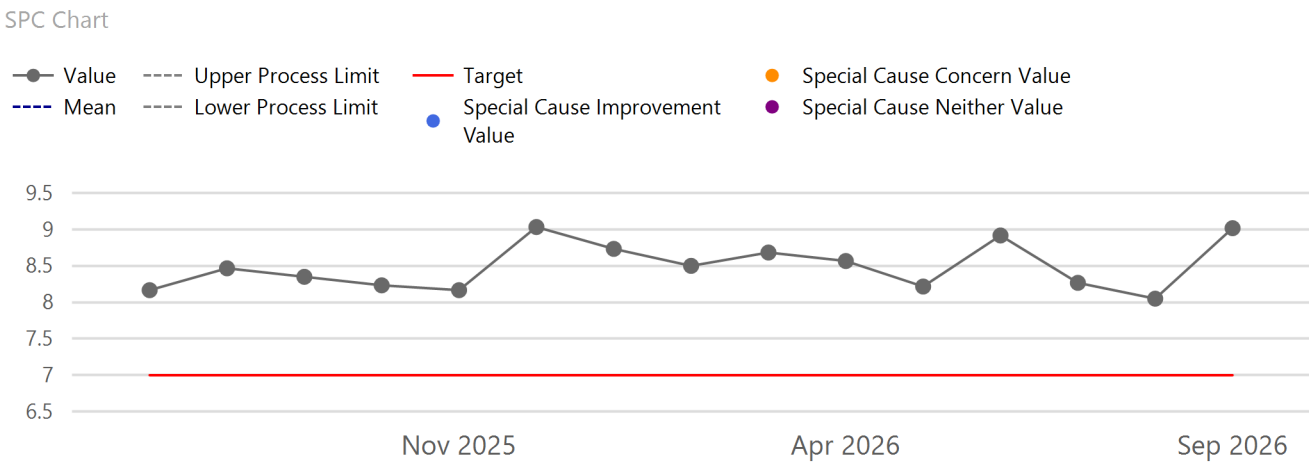
n/a

Concerns

n/a

Metric ID: 10000148 Median emergency ambulance response time to red: emergency category calls

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	8.1667	7	F		Chief Operating Officer



Narrative

This measure is owned by WAST and the national data is currently under review. The C&V approach for reporting against these measures will be reviewed as part of the next phase of IPR development

Actions and Owners

n/a

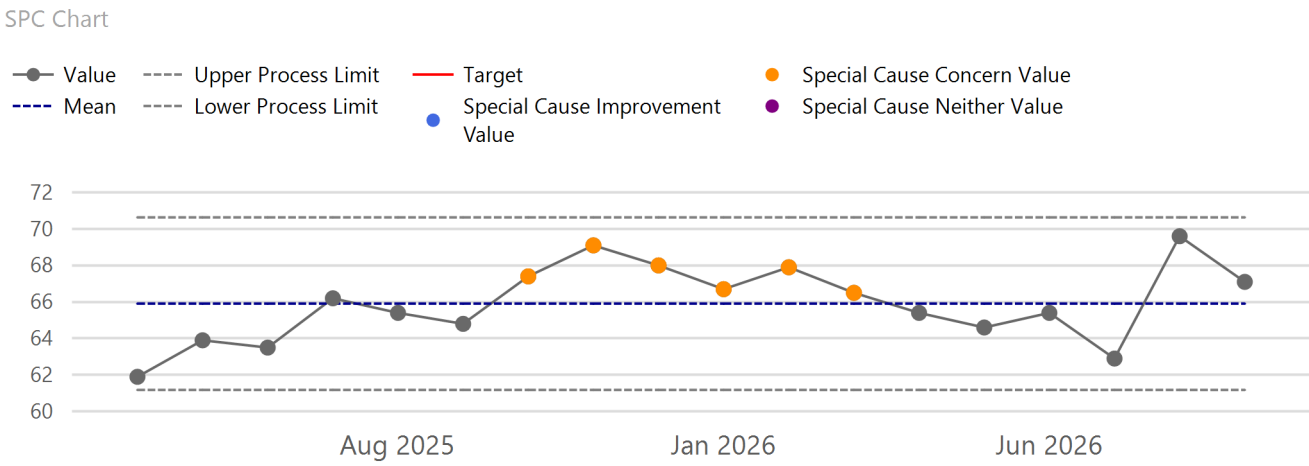
Concerns

n/a

Metric ID: 10000149

Percentage of R1 patient pathways, which have a target date allocated, waiting within their clinical target date or within 25% beyond their clinical target date for an outpatient appointment

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	61.9				Chief Operating Officer



Narrative

Consistent performance but not always meeting de-escalation requirement. The R1 cohort is predominantly made up of Glaucoma and Medical Retina Patients. We have gone live with our Glaucoma Diagnostic Unit which will allow us to see all our R1 Glaucoma patients in a timely manner.

Actions and Owners

Progressing business case to increase capacity for Medical Retina patients.

Working with Primary Care on pathway for Diabetic patients to reduce lower grade referrals and free capacity to see urgent patients in a more timely manner

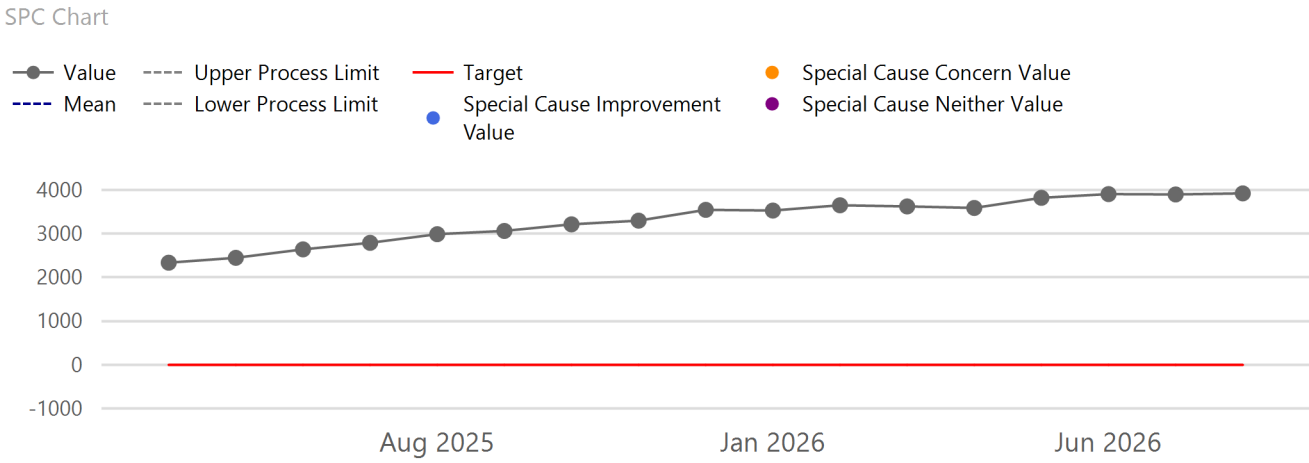
Concerns

Not consistently meeting de-escalation requirement

Metric ID: 10000150

Number of adults waiting more than 14 weeks for all audiology pathways (to include new and existing pathways for hearing aids, tinnitus and balance)

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	2337	0	F		Chief Operating Officer



Narrative

We have seen an increase in the audiology waiting list through the last year driven by an increase in demand. 14 week waits have increased as capacity within the service is unable to match the increase. This has been observed in our neighbouring health boards with similar deterioration in 14-week performance. Clinical triage of referrals ensures urgent cases are identified and booked directly into the appropriate clinic.

Actions and Owners

Service are developing a text reminder service to reduce DNAs and validate patients who no longer need an appointment

3 audiologist posts recruited - starts dates in Q2 and Q3 - providing additional capacity

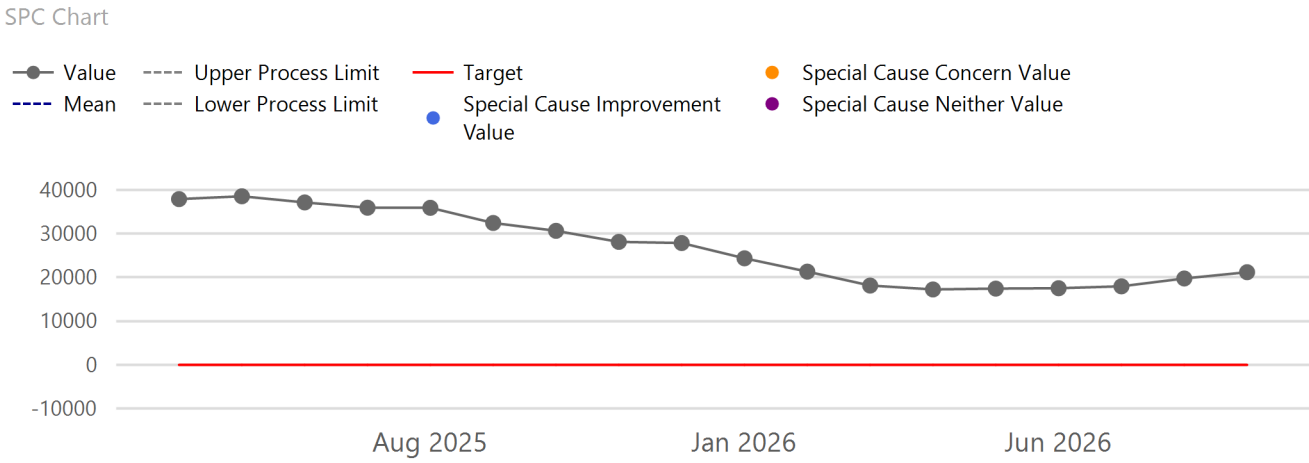
Concerns

Increasing demand and insufficient capacity to meet the waiting times standard

Metric ID: 10000151

Number of patients waiting more than 26 weeks for a new outpatient appointment

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	37914	0	F		Chief Operating Officer



Narrative

Significant reduction in the volume of long waiting outpatients through last year as a result of the National and Local outpatient insourcing work. An additional 22k appointments were delivered through the national scheme, with a further 9k through C&V schemes. This activity ceased in March 2026 and we have seen recent increases in 26 week waits

Actions and Owners

Outpatient improvement summit in July 2026.
From Q3 - overbooking of outpatient clinics to mitigate the impact of patient DNAs.

Focus on use of SOS/PIFU to free up follow-up capacity for new patients

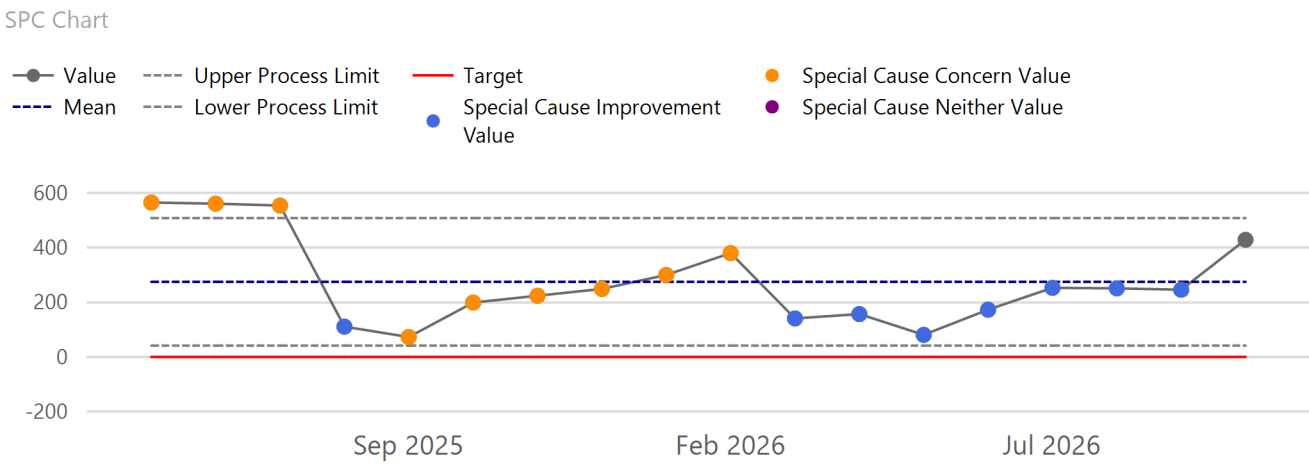
Actions and performance monitored through the newly established Productivity and Efficiency Board

Concerns

Increase in waits without additional activity

Metric ID: 10000152 Number of ambulance patient handovers over 45 minutes

Latest Month	Value	Target	Assurance	Variation	Metric Owner
October 2026	565	0	F		Chief Operating Officer



Narrative

Our current performance remains improved from last year, but we see fluctuations in line with operational pressures in the EU and across the inpatient and assessment areas. In May 95% of handovers were completed within 45 minutes, this has reduced through the Q2 and 3, with 77% reported in October in line with periods of significant operational pressures in month. We continue to focus on urgent and emergency care as we look to maintain this improvement with our ambition this year to maintain at least 95% of handovers within 45 minutes. All 45 minutes breaches are audited on a weekly basis

Actions and Owners

Suite of actions to support EU and flow:
Update and refresh of acute referral policy
Escalation triggers moved to 15 and 30 minutes
ACU desk to coordinate timely clinical responses
Acute physician pull model from ambulatory areas direct to Medical SDEC
Phase 1 of acute remodel - frailty assessment
Actions and performance metrics monitored through UEC Programme Board

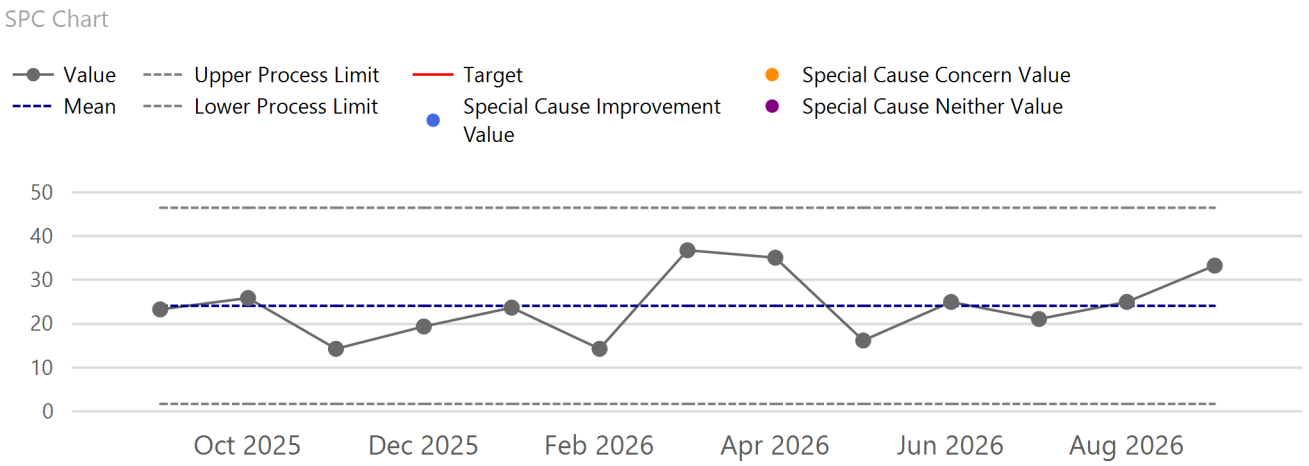
Concerns

Maintaining ambulance performance during periods of high escalation

Metric ID: 10000161

Percentage of people to have a heartbeat restored after a period of cardiac arrest which is subsequently retained until arrival at hospital (Return Of Spontaneous Circulation)

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	23.3				Chief Operating Officer



Narrative

This measure is owned by WAST and the national data is currently under review. The C&V approach for reporting against these measures will be reviewed as part of the next phase of IPR development

Actions and Owners

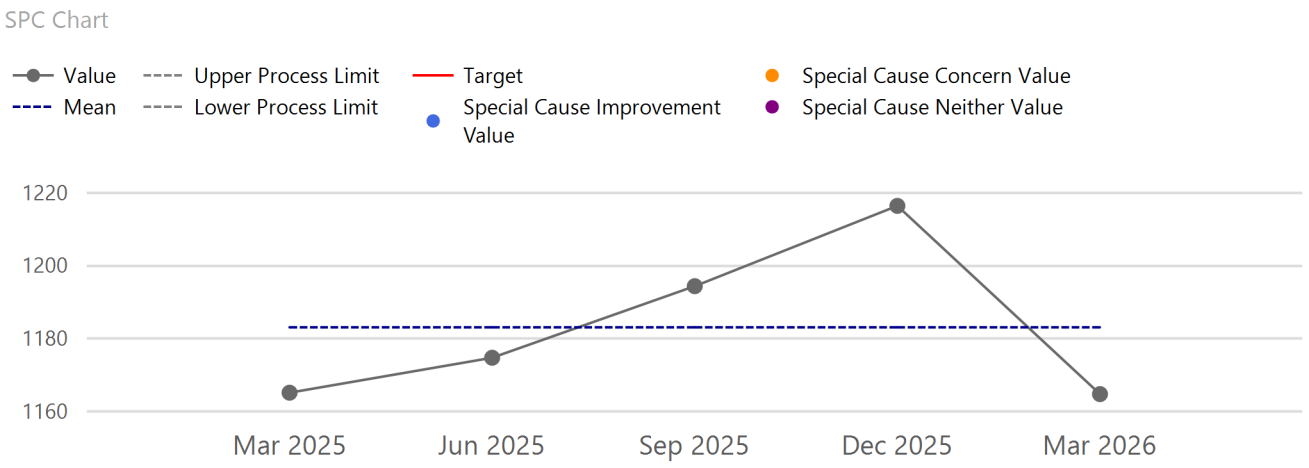
n/a

Concerns

n/a

Metric ID: 10000162 Gabapentin and pregabalin DDDs per 1,000 patients

Latest Month	Value	Target	Assurance	Variation	Metric Owner
March 2026	1165.2				Chief Operating Officer



Narrative

Currently the best performing health board in Wales, and below all NE England CCGs and the English average. The second-best performing HB is over 16% higher than CAV UHB.

Early proactive work to deviate from the trend early and avoided the scale of increased prescribing that other Health Boards experienced.

Various projects and education pieces have been undertaken over the last decade to promote appropriate prescribing to both primary care prescribers and specialist teams, agreeing and adherence to prescribing pathways and routes to deprescribing.

Actions and Owners

Focus remains on decreasing inappropriate prescribing and prescribing safely.

Project focussed on safe prescribing included in the 2026/27 Medicines Management Incentive Scheme for GP practices.

PCIC medicines management team to promote the All Wales gabapentinoid resources for chronic pain once published.

Concerns

Ability to decrease prescribing, when prescribing is already in the lowest quartile of all England and Wales areas, is difficult.

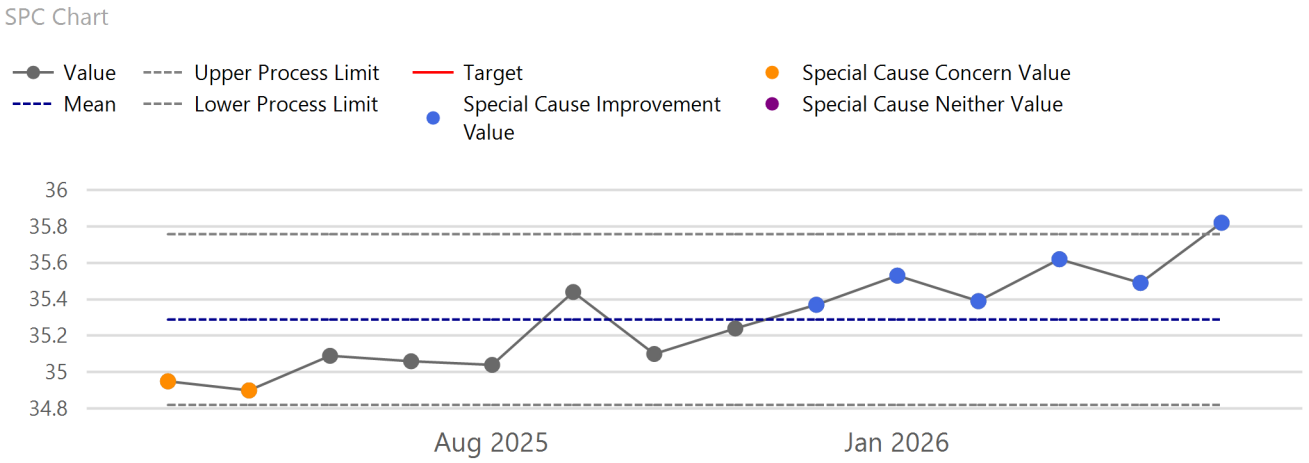
A drive to reduce gabapentinoid prescribing may cause an increase is other analgesia e.g. opioid prescribing, which may also pose safety concerns and be measured in other indicators.

Change takes time and relies on clinician and patient engagement and management of expectations.

Metric ID: 10000163

Average quantity per item prescribed from start period for the reference basket of medicines

Latest Month	Value	Target	Assurance	Variation	Metric Owner
May 2026	34.95				Chief Operating Officer



Narrative

Currently the best performing health board in Wales, with the highest quantity per prescription item and the greatest percentage change from the start of data collection.

The only Health Board in Wales already above the prescribing interval target of 35 days (achieved June 2025).

The Welsh Government response to the Dispensing Volume Review (Jan 2022) and the All Wales Medicines Strategy Group guidance (October 2022) has been promoted to GP practices, Clusters and also with specialist teams within the wider UHB, when opportunity allowed. It has consistently been included in prescribing messages to GP practices at annual prescribing meetings, and engagement has been promoted via Community Pharmacy Collaboratives as well.

Actions and Owners

Continued promotion to GP practices.

A National Prescribing Intervals Short Life Working Group is currently meeting. Health Board actions from this group will be considered once published.

Concerns

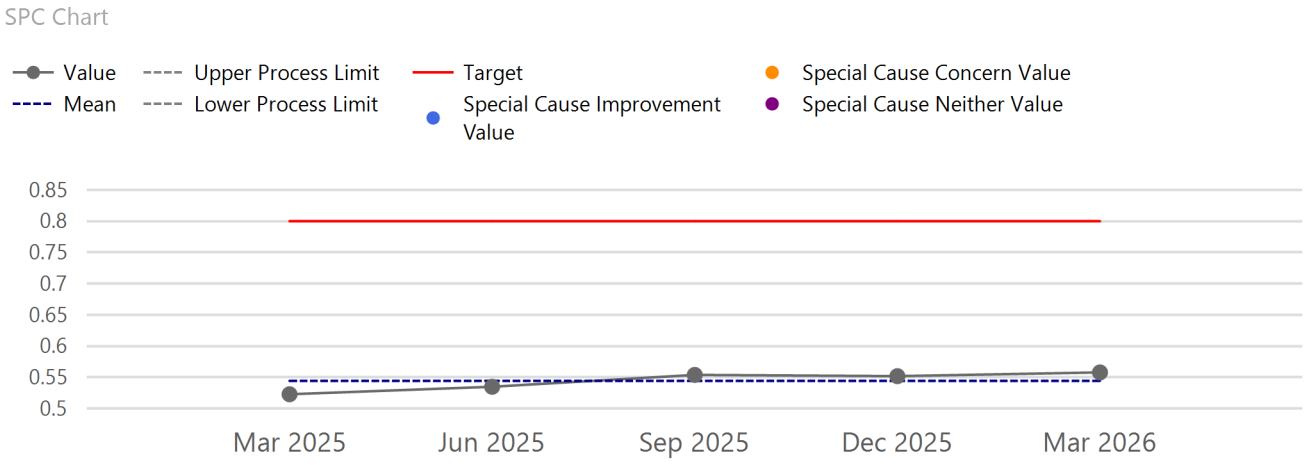
Implementation is limited by patient suitability for extended intervals of prescribing. Some patients and some medications are not suitable for this initiative.

Risk that promoting a fast pace of change will mean inappropriate patients are selected for this change which could lead to confusion, harm, increased waste along with increased workload and disengagement.

Metric ID: 10000164

Number of low Global Warming Potential (GWP) inhalers as a percentage of all inhalers prescribed

Latest Month	Value	Target	Assurance	Variation	Metric Owner
March 2026	0.523	0.8			Chief Operating Officer



Narrative

Currently the best performing health board in Wales, and above all NE England CCGs and the English average. Improvement continues.

Concerted work started in 2021/22 with heavy promotion of the All Wales Respiratory Guidance across all GP practice workforce, QI projects as part of the Medicines Management Incentive Scheme for GP practices as well as the PCIC medicines management team's work programme. In 2022/23 the Green Inhaler GMS QI project promoted the message further and learning from this project continues to embed.

Actions and Owners

Continued promotion of message to primary care workforce.

Identification and engagement with outliers.

Concerns

Change takes time given the volume of inhalers prescribed – some inhalers necessitate different technique which requires patient counselling.

Increasing amount of low carbon footprint inhalers are coming to market so indictor subject to change.

Risk that prescribing spend may increase as low carbon footprint inhalers are often more expensive.

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

Winter Preparedness and GIRFT Recommendations

Weekly Winter Cabinet oversight, with named owners, weekly milestones and clear metrics for every scheme.

KEEP WELL — Prevention and proactive care
AVOID ADMISSION — Community alternatives
FRONT DOOR — Right stream, first time
FIRST 72 HOURS — Rapid decision and turnaround

1 Vaccination and winter IPC

Link vaccination to hospital IPC patient cohorting through winter.

Measure: uptake; crisis avoided

Owners: Public Health / PCIC SRO, practice nurse developers and Yvonne Hyde (IPC lead nurse)

2 Single point of access (CAV 24/7) and falls

Provide a single point of access through CAV 24/7 and a rapid response for falls.

Measure: conveyances avoided; admission rate; response time; referrals; acceptance; bed-days saved

Owners: Sherard Le Maitre and Emma Lewis, Rachel Thomas, with WAST input

GIRFT

3 Decongestion and avoidable EU demand

Co-located UTC and nurse-led streaming, with clear diagnostics and escalation. Improve ambulance handovers.

Measure: % streamed; EU conversion; 12h waits

Owners: Clare Davies / Ceri Martin / Jenelle Courtney / Rhys Andrews/ Emma Lewis / Vicky Hicks

4 Acute frailty pathway

Identify frailty earlier, provide senior review and offer same-day alternatives.

Measure: frailty activity; conversion; LoS; same-day discharge

Owners: Siobhan Lewis, Claire Main and Katja Empson, with support from PCIC

5 Same Day Emergency Care

Increase same-day activity and extend senior decision-making into the evening.

Measure: MSDEC +10%; same-day discharge; decision time

Owners: Chris Carrington and Cari Randall

GIRFT

6 Improved specialty response and ownership

Clinical operational standards (Acute referral policy): timely specialty response, clear accountability, 90-minute escalation and completion.

Measure: response time; breaches; specialty referrals; outliers

Owners: Jody Parker/ Rhian Grapes / Peter Burrow/ Emma Keen

Cabinet test: are these schemes reducing arrivals, conversion and avoidable bed demand fast enough to protect acute capacity?

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

Winter Preparedness and GIRFT Recommendations

Weekly Winter Cabinet oversight, with named owners, weekly milestones and clear metrics for every scheme.

RIGHT CARE Referral and specialty response › **INPATIENT FLOW** Seven-day senior grip › **DISCHARGE** No avoidable delay › **RECOVERY AT HOME** Bed-equivalent capacity

GIRFT

7 Seven-day continuity of care

Consultant-of-the-week: daily senior decisions, senior nurse cover and MDT ward/board rounds, with reliable weekend decisions and discharges.

Measure: daily compliance; weekend decisions and discharges

Owners: David Hanna / Ceri Phillips / Anne Marie Morgan

GIRFT

8 Reduced and variable Medical discharges

Ward Excellence: criteria-led discharge across agreed pathways, earlier planning, named next action and Red to Green, including weekends.

Measure: pre-midday discharge; CLD use; LoS; weekly discharges

Owners: Omar Aldalati/ Sandeep Berry / Emma Davies / Fiona Davies / Vicci Page / Hadas Reshef

9 Pathway of Care Delay Reduction

Use rigorous 7/14/21-day reviews and partner action to release 300 bed-days.

Measure: POCD volume; 300 bed-days; action closure

Owners: Stephine Wells, Georgina Hunt, Barbara Davies and Fran Woodcott

10 End-of-life and supportive care

Identify need earlier and provide rapid community support for preferred place of care.

Measure: referrals; time to package; 8 bed-equivalents

Owners: Clea Atkinson and Molly Baker

GIRFT

11 Alternatives to Admission and bed-equivalent capacity

Virtual Smart Care: CRT and Safe@Home support care homes and COPD / respiratory care, avoiding admission and enabling earlier discharge.

Measure: activity; readmission; LoS; bed-equivalent capacity

Owners: Katja Empson/ Richard Lea / Rachel Lee /Emma Davies / Barbara Davies/ Mike Bond

GIRFT

12 OPAT: Operational Planning and Transformation & Integrated Discharge Service

Hospital and site teams coordinate flow 24/7 for resilience, share information and agree actions and escalation.

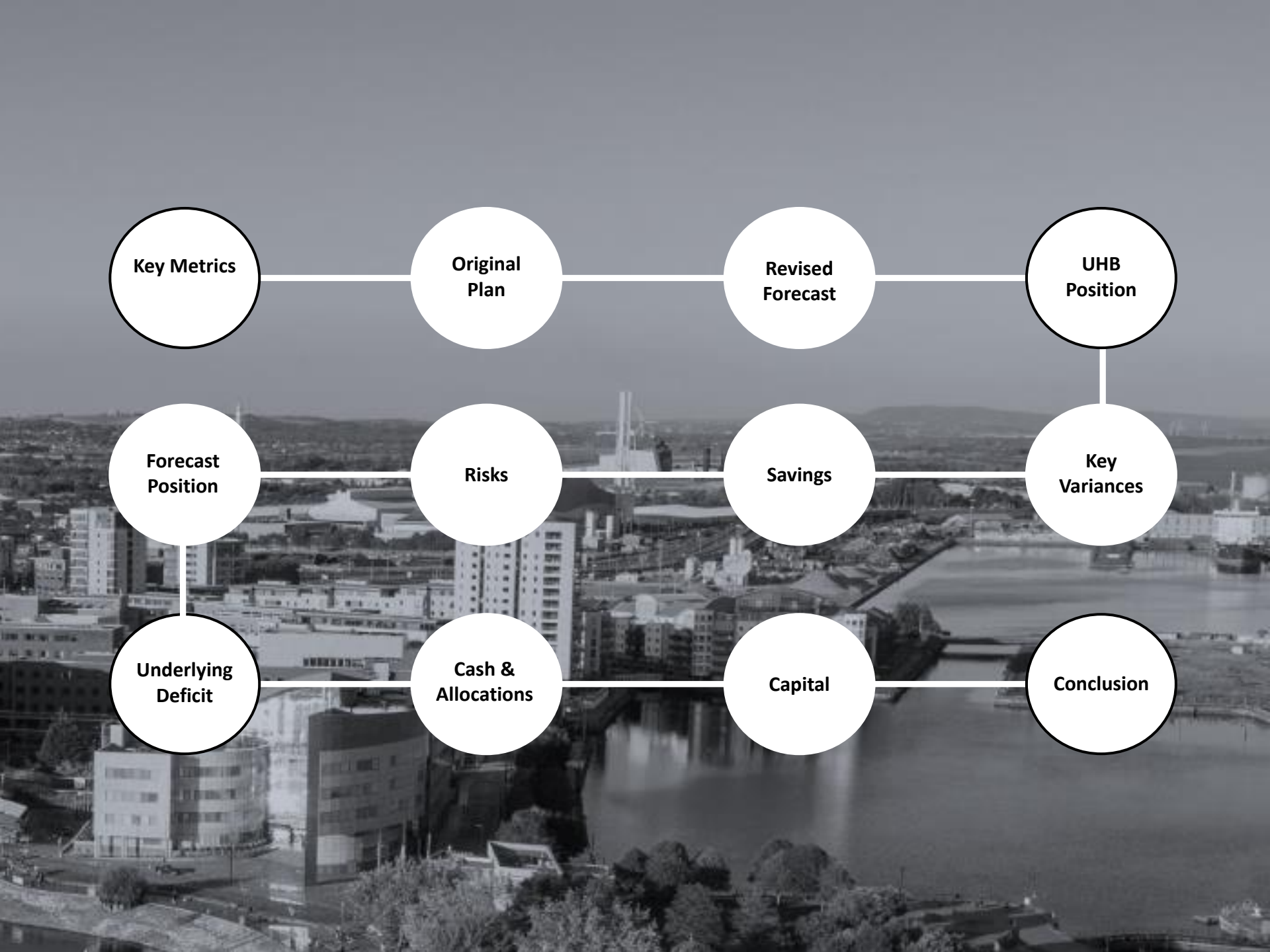
Measures: To confirm

Owners: To confirm

WINTER CABINET | weekly RAG, milestone and benefit review • one owner per scheme • quantified trajectory • decision log • rapid escalation of material exceptions

CARDIFF & VALE UHB
FINANCE REPORT – MONTH 07




Key Metrics
Original Plan
Revised Forecast
UHB Position
Forecast Position
Risks
Savings
Key Variances
Underlying Deficit
Cash & Allocations
Capital
Conclusion



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

Measure	Description	RAG	Trend	Target	Time Period
Deliver 2026/27 Deficit Target Control Total	The revised forecast deficit of £77.4m needs to be derisked urgently with a clear cash releasing plan. There is currently a significant gap to delivery.	R	↓	£77.4m	M07 2026/7
Return to financial balance and approved IMTP status	Following the revision to the Welsh Risk Pool Conntribution the forecast underlying deficit has reduced from 86.5m to £77.4m by the end of 2026/27 financial year. Currently reporting a recurrent savings gap of £24.7m after Month 07.	R	↓	£77.4m	M07 2026/7
Management of operational budget pressures	Failure to adequately manage budget pressures. This is the responsibility of the primary budget holders. (£3.8m) operational surplus reported at Month 07.	A	→	Operational Spend to be maintained within Budgets	M07 2026/7
Delivery of the **recurrent** £42.5m core & £5.1m JCC savings target	£29.8m of Green and Amber-rated schemes had been identified by Month 7, of which £22.9m were classified as recurrent.	R	↑	£42.5m plus £5.1m (47.6m in total)	M07 2026/7
Remain within Cash Limit	The UHB will require cash support from Welsh Government (WG) for the 26/27 planned deficit of £77.4m along with likely movements in working capital from the 2025/26 balance sheet.	A	→	To remain within Cash Limit	M07 2026/7



Following confirmation at Month 7 of a £9.1 million reduction in the UHB's contribution to the Welsh Risk Pool for 2026/27, the initial planned deficit of £86.5 million has been revised to a forecast deficit of £77.4 million. The UHB's Revised Forecast Deficit in 2026/27 reflects the following key components:

Planning Assumptions	(£m)
Brought Forward Underlying Deficit	68.8
2026/27 Demand/Cost Growth/Improvement	54.7
2026/27 Increase in Contribution to Welsh Risk Pool	21.5
Deficit	**144.9**
Additional Allocations	(15.9)
Savings Plans	(42.5)
Initial Planned Deficit	**86.5**
Reduction to 2026/27 Contribution to Welsh Risk Pool confirmed Month 6	(9.1)
Revised Forecast Deficit £m	**77.4**

Following consideration by the UHB Board, a financial plan, which included a forecast deficit of £86.5m was submitted to the Welsh Government at the end of March 2026. In response to feedback from the Welsh Government, the Health Board wrote on 29 May 2026 confirming its intention to de-risk the financial plan by the end of Quarter 2.

The plan recognised the combined £5.4m recurrent savings shortfall and £7.1m recurrent operational pressures totalling £12.5m that arose during 2025/26, resulting in a brought forward underlying deficit of £68.8m. Recurrent operational benefits delivered during the year are either reflected within the savings plan or offset against other recurrent operational pressures in arriving at the brought-forward underlying deficit

Material recurrent operational pressures recognised in addition to the 2026/27 plan include:

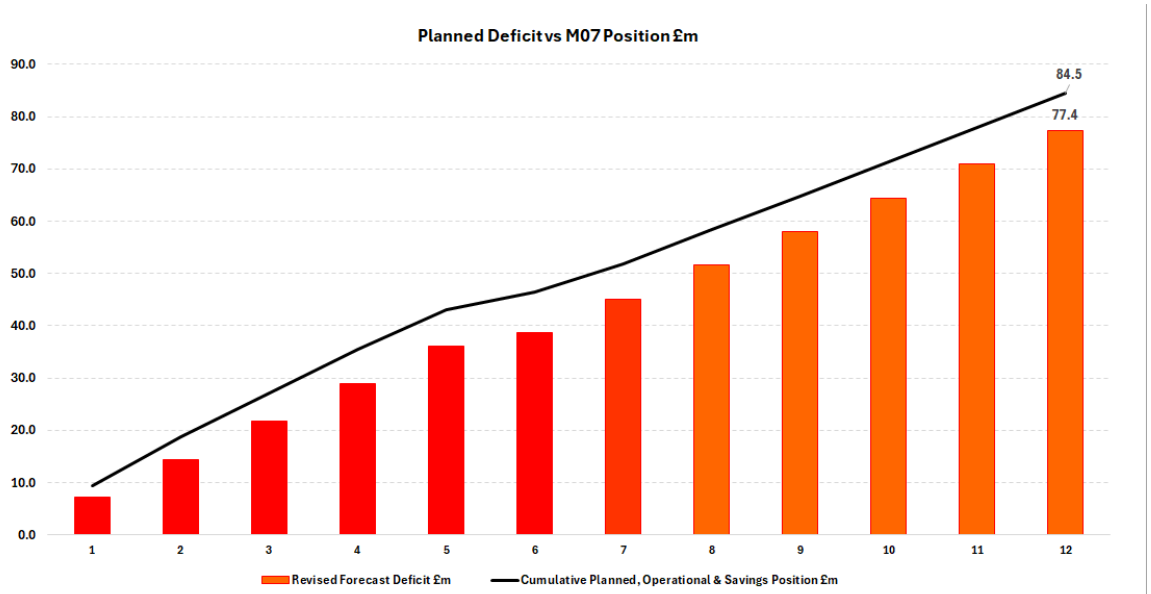
- £2.3m – Band 2-3 HCSW Implementation
- £2.1m – Increase in Employers National Insurance
- £0.9m – Mental Health Out of Area patients
- £0.8m – GP OOHs Contract
- £0.7m – Common Ailment Scheme
- £0.6m – Midwifery Streamliners

The revised forecast, reflecting the reduction in the Welsh Risk Pool contribution, continues to project a deficit for the financial year. As a result, the UHB will not meet its statutory requirement to deliver a balanced financial plan over the rolling three-year period. Consequently, the plan and revised forecast is unable to secure Ministerial approval.



UHB Position

The graph below shows the reported Month 07 position against the UHB's revised forecast deficit of £77.4m



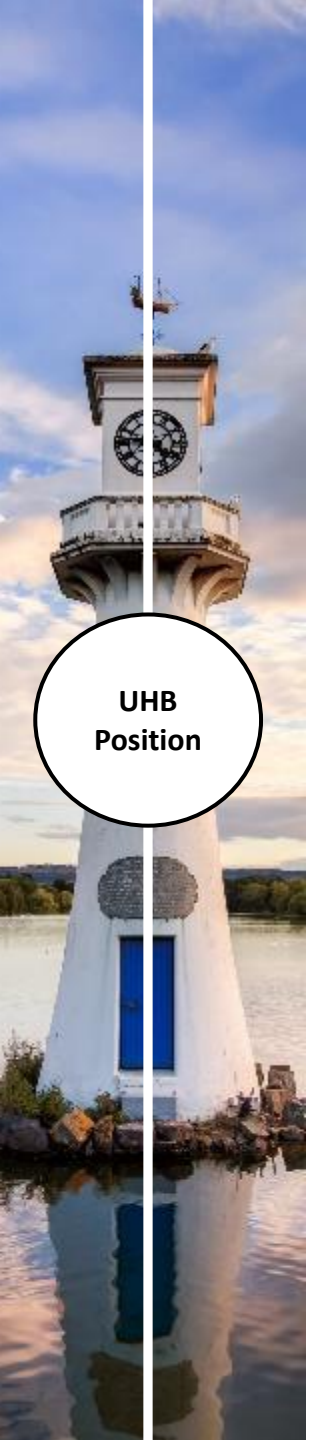
	1	2	3	4	5	6	7	8	9	10	11	12
Revised Forecast Deficit £m	7.2	14.4	21.6	28.8	36.1	38.7	45.1	51.6	58.0	64.5	70.9	77.4
Cumulative Planned, Operational & Savings Position £m	9.4	18.8	27.1	35.5	43.1	46.4	51.8	58.3	64.8	71.4	77.9	84.5
Actual/ Forecast Deficit above Plan £m	2.2	4.4	5.4	6.7	7.1	7.7	6.6	6.7	6.8	6.9	7.0	7.1
25/26 deficit outturn of £56.1m	6.1	11.9	15.2	21.2	27.8	31.8	35.6	40.2	43.3	47.4	51.6	56.1

The monthly planned deficit is profiled on a straight-line basis in line with Welsh Government guidance. The change in profile from Month 6 reflects the £9.1m reduction in the Welsh Risk Pool contribution, which is an external funding adjustment, and does not alter the need to deliver savings and maintain expenditure controls.

The current forecast outturn is a deficit of £84.5m against the revised forecast target of £77.4m which represents the current forecast before further recovery actions.

Executive-led turnaround meetings have been established with each Clinical and Service Board to support recovery actions and recurrent financial sustainability. In addition, external support has been engaged to accelerate transformation work and identify further efficiencies.

Whilst this is expected to strengthen financial recovery arrangements, the extent and timing of benefits remain uncertain and may not fully address the residual gap to the forecast deficit position.



The forecast deficit has reduced from the original plan of £86.5 million to £77.4 million, reflecting a £9.1 million reduction in the UHB's contribution to the Welsh Risk Pool for 2026/27 which was confirmed in month 6. The UHB is reporting a year to date overspend of £51.8m at month 07, which includes the forecast deficit £45.1m, a Savings Programme shortfall of £10.4m and an Operational Position surplus (£3.8m)

	Revised Forecast Deficit PTD (£m)	PTD (£m)	PTD Variance to Revised Forecast Deficit (£m)	Revised Forecast Deficit YTD (£m)	YTD (£m)	YTD Variance to Revised Forecast Deficit (£m)	Revised Forecast Deficit (£m)	Forecast	Variance to Revised Forecast Deficit (£m)
Revised Plan	9.8	9.8	0.0	69.4	69.4	0.0	125.0	125.0	0.0
Quality Efficiency Improvement Plans - Savings	3.4	3.5	0.2	24.3	13.9	10.4	47.6	29.8	17.8
Operational Variance	0.0	0.9	0.9	0.0	3.8	3.8	0.0	10.8	10.8
Clinical/Service Board Variance	**6.4**	**5.4**	**1.0**	**45.1**	**51.8**	**6.6**	**77.4**	**84.5**	**7.1**

The cumulative overspend against plan fell by £1.0m in month, reflecting an improvement in savings delivery and the operational position.

Achievement of the revised forecast deficit of £77.4 million remains challenging and requires urgent mitigation. Key risks to delivery currently include:

1. **Savings Delivery**
   - A forecast shortfall of £13.9 million against the core £42.5 million savings target and with an additional £3.9 million shortfall against the £5.1million JCC savings target.
   - The current red-rated savings pipeline totals £18.4 million. While full delivery would achieve the core & JCC savings target, there is a significant risk that not all schemes will be realised, requiring further opportunities to be identified
   - £1.2m of green and amber schemes have been identified against the £5.1m JCC efficiency target, with a further £0.3m of red schemes under assessment.

2. **Underlying Financial Position**
   - Year-to-date operational underspends from pay vacancies, commissioning and medicines management have offset wider expenditure pressures.
   - Significant financial pressures continue within medical staffing, endoscopy services, mental health out-of-area placements, reductions in private patient activity and the reformed resident doctors contract, posing a material risk to delivery of the revised planning deficit.

Progress in developing and implementing additional savings plans must continue to ensure the UHB can achieve its revised forecast deficit target of £77.4m



Key Variances

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	**£'m**	**£'m**	**£'m**	**£'m**
Budget	62.8	91.3	101.3	**129.9**
(Income)/Expenditure	62.9	91.7	106.5	**135.3**
Variance	**0.1**	**0.4**	**5.1**	**5.4**
Cumulative	**£'m**	**£'m**	**£'m**	**£'m**
Budget	402.4	633.0	657.9	**888.5**
(Income)/Expenditure	402.5	632.5	710.2	**940.2**
Variance	**0.0**	**0.5**	**52.3**	**51.8**

A number of operational pressures continued into month 07 which in turn have been offset by pay vacancies.

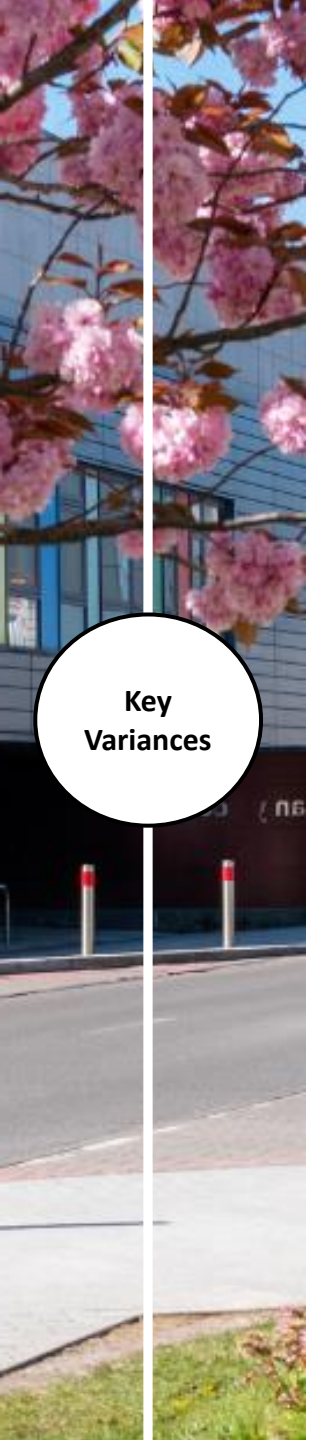
The following operational issues were reported at month 07 in 2026/27:

The analysis above indicates a year-to-date overspend of £51.8 million, which is a £6.6 million adverse variance to the forecast year-to-date deficit.

- Income – An in month surplus of £0.1m is reported with improved performance in R & D offset by underperformance across a number of areas.

- Pay: Vacancies continue to generate savings, offset by pressures from specialist medical locum expenditure. Phase 1 of the new Resident Doctors' Contract was implemented in August and is currently forecast to result in an additional £1.2m cost pressure in 2026/27. The estimate will be refined as further payroll and funding information becomes available, particularly in relation to overtime and enhancement payments.

- Non Pay – A £1.1m overspend relating to endoscopy insourcing and £1.2m for Mental Health Out of Area Patients are reported for the Year to Date . Excluding these issues, the majority of the remaining overspend is attributable to the underlying planning deficit and a shortfall in savings delivery.



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

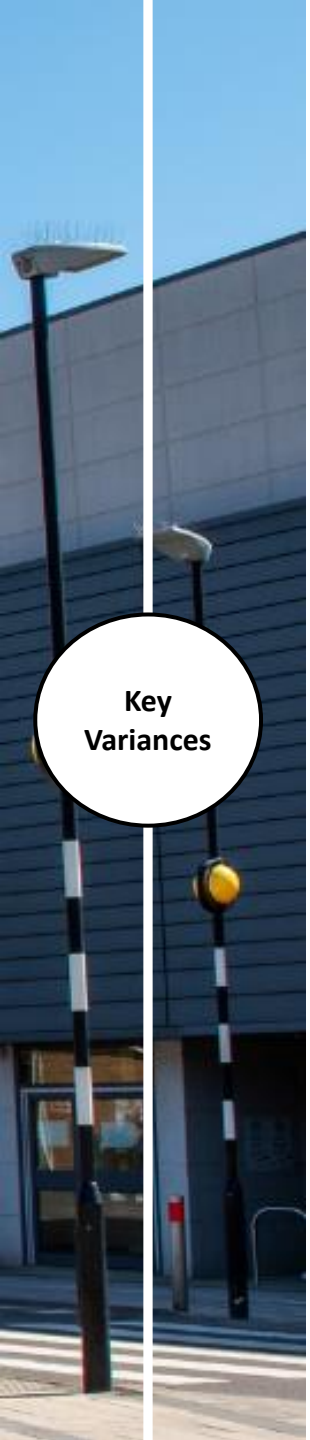
Business Unit	Forecast Deficit (£m)	Savings (£m)	Operational (£m)	Total (£m)	Variance to Forecast Deficit (£m)
Clinical Diagnostics & Therapeutics	1.1	1.3	0.4	**2.0**	0.9
Children & Women	4.4	3.5	0.3	**7.6**	3.2
Capital, Estates & Facilities	1.1	1.1	1.2	**1.2**	0.1
Executives	0.7	0.7	0.1	**0.0**	0.7
Genomics	0.2	0.0	0.2	**0.0**	0.2
Medicine	8.2	1.1	0.2	**7.3**	0.9
Mental Health	6.2	1.0	2.5	**9.8**	3.5
Primary, Community & Intermediate Care	5.1	0.4	3.8	**0.9**	4.2
Specialist	3.2	4.5	2.2	**9.9**	6.7
Surgery	1.1	1.0	0.2	**2.3**	1.1
Sub-Total (Delegated Position)	**27.8**	**11.6**	**0.8**	**38.5**	**10.8**
Central Budgets	2.4	0.0	0.3	**2.0**	0.3
Commissioning	15.0	1.2	2.6	**11.2**	3.8
Sub Total (Non-Delegated Position)	**17.3**	**1.2**	**2.9**	**13.2**	**4.1**
Sub-Total Surplus/Deficit	**45.1**	**10.4**	**3.8**	**51.8**	**6.6**



The table/chart below summarises the key 2026/27 Operational pressures and underspends as at month 07:

Operational Pressure & Savings Shortfall	Variance YTD £m	Variance Forecast £m
Operational:		
Medicine Endoscopy Insourcing	1.1	1.2
Mental Health OOA Placements	1.2	0.3
Specialist Medical Locum Usage	0.2	0.3
Specialist private patient activity reductions	0.8	1.4
Resident Doctors Contract	0.5	1.2
Programme Slippage (incl. Value)	0	-1
Release of Deferred R&D Income	0	-0.5
Procurement Opportunities	0	-0.9
LHB Expenditure Reduction & JCC Commissioner	-2.6	-2.9
Medicines Management (Primary Care & NICE)	-1.8	-3.2
Vacancies and other net pay underspends	-3.2	-6.7
Savings Shortfall	**10.4**	**17.8**
Sub-Total Surplus/Deficit	**6.6**	**7.1**

- The forecast endoscopy pressure is being offset by scheme slippage and pay vacancies.
- Mental Health out of area patients (numbers reduced significantly in month with an improved forecast)
- Specialist Medical Locum use is primarily driven by specialist services.
- The Commissioner surplus is driven by JCC slippage and a reduction in the cost of outflows.
- The medicines management underspend is generated by reduced cost in primary care and cost avoidance schemes.
- The revised Wales Resident Doctors' Contract introduces a new pay structure, enhanced rates for out-of-hours work, improved overtime payments, strengthened fatigue safeguards, protected study leave, and measures supporting recruitment and retention.
- The forecast benefit arising from programme slippage and the release of deferred R&D income is non-recurrent in nature.
- It is expected that all unplanned cost pressures arising in 2026/27 will have corresponding mitigations identified to deliver the submitted £77.4m revised planning deficit. Any continuation of unplanned cost pressures beyond March 2027 is not currently reflected as a deterioration in the underlying deficit position, on the basis that appropriate mitigating actions are expected to be identified.



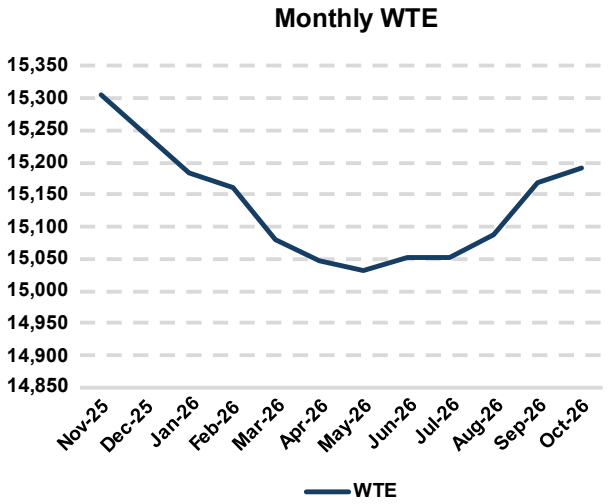
Key Variances

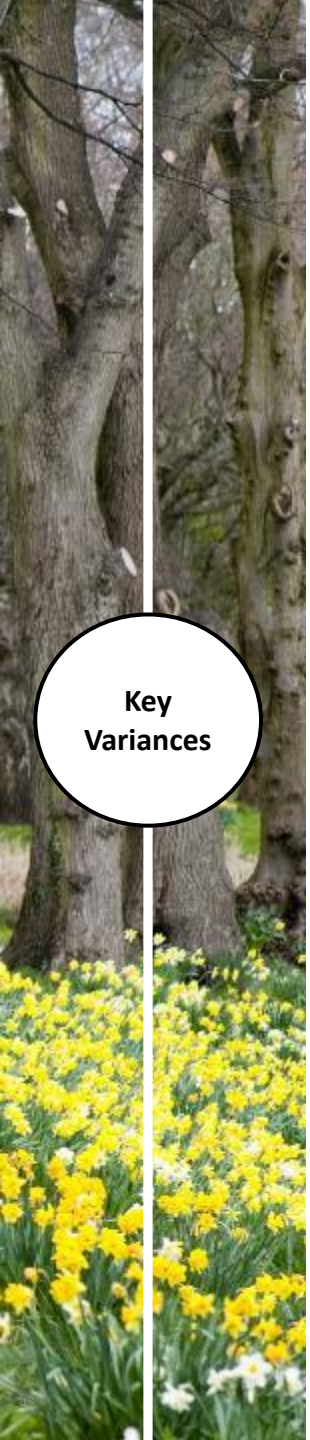
The table/chart below summarise the 2025/26 & 2026/27 Pay expenditure run rates at month 07 for all staffing groups :

Staffing Group	2025/26 YTD (£m)	2026/27 YTD (£m)	2026/27 vs 2025/26 Growth (£m)	2026/27 vs 2025/26 Growth (%)
Additional Clinical Services	22.6	22.6	(0.0)	-0.2%
Management, Admin & Clerical	74.8	77.1	2.3	3.1%
Medical and Dental	168.7	176.6	7.9	4.7%
Nursing (Registered)	173.1	180.3	7.2	4.1%
Nursing (Unregistered)	51.0	52.4	1.4	2.8%
Other Staff Groups	90.5	94.1	3.5	3.9%
Scientific, Prof & Technical	28.3	29.4	1.1	3.9%
Total	**609.1**	**632.5**	**23.4**	**3.8%**

Increased pay expenditure is mainly driven by the 2025/26 and 2026/27 pay awards and the Resident Doctors Contract for Wales, with most of the increase funded through additional Welsh Government support.

The chart (right) reports substantive WTE by month and shows a 115 WTE reduction across the UHB over the last 12 months. From November through to October, WTEs in post have declined overall. Growth in WTEs accelerated in September, driven primarily by student streamliner recruitment within Allied Health Professionals and Nursing, with further growth continuing into October.





Key Variances

The table below reports year-to-date growth versus 2025/26 and outlines the run rate for Non Pay expenditure.

Non Pay Group	2025/26 YTD (£m)	2026/27 YTD (£m)	Growth (£m)	Growth (%)
Clinical Services & Supplies	76.3	79.7	3.4	4.5%
Continuing Healthcare	69.1	76.3	7.2	10.4%
Drugs / Prescribing	159.1	166.7	7.7	4.8%
Healthcare Provided Services	172.5	179.7	7.1	4.1%
Other Non Pay & General Supplies and Establishment Expenses	63.9	68.8	4.9	7.6%
Premises & Fixed Plant	31.3	32.9	1.5	4.9%
Primary Care Contractors	96.9	106.1	9.2	9.4%
Total	**669.2**	**710.2**	**41.0**	**6.1%**

The UHB reported **£710.2m** of Non Pay expenditure for the Year to Date to October 2026 which is an increase of 6.1% on the same period in the previous year. The large part of the increase is driven by expenditure in the following areas:

- Price and demand in Continuing Healthcare (CHC) which includes growth of 17% in Mental Health CHC costs.
- Healthcare Provided Services. Additional Commissioning costs including Mental Health Out of area Placements, Velindre NHST and JCC under Healthcare Provided Services. (£4.0m of the YTD additional cost relates to the 2025/26 pay award and increase in National Insurance Employers costs where the UHB has received additional funding from Welsh Government to cover)
- The increase in premise & plant costs is primarily driven by rates, maintenance, IT and engineering contracts.
- Primary Care contracts (including Welsh Government funded contractual uplifts for 2025/26 and 2026/27 GMS and 2025/26 for Dental & Pharmacy).



Savings

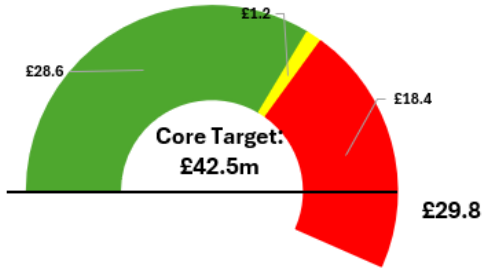
At Month 7, £29.8m of green and amber savings have been identified against the combined £47.6m core (£42.5m) and JCC (£5.1m) savings target, with a further £18.4m of red-rated schemes identified. While the target is currently covered, delivery remains reliant on higher-risk red schemes, increasing the overall risk of achievement.

Further action is required to meet the recurrent targets and the UHB continues to press all parts of the organisation to agree urgent actions that will accelerate savings to mitigate the ongoing risk. £22.9m of recurrent savings were identified at month 07 leaving a gap of £24.7m against the combined £47.6m core (£42.5m) and JCC (£5.1m) recurrent target.

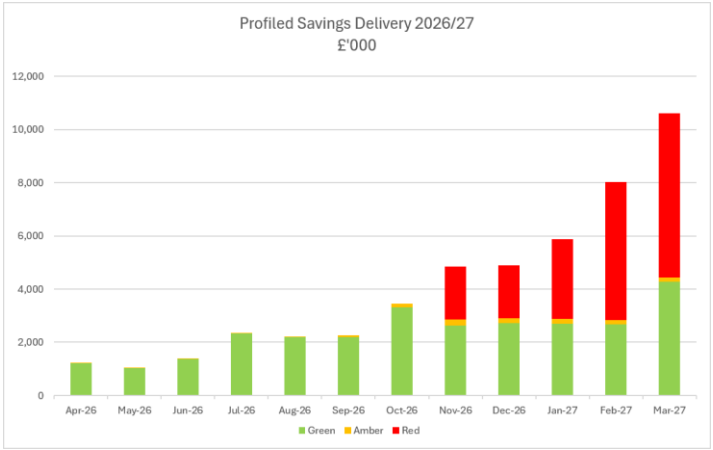
In year Green and amber schemes totalling £1.2m have been identified against the JCC £5.1m (2%) efficiency target. A further £0.3m of red schemes are being assessed, with work ongoing to develop additional savings schemes.

The charts to the right and below illustrates the themes and profile of the UHB's 2026/27 core savings programme.

2026/27 UHB Core Savings Programme: Identified vs Requirement £m



Area of Cost Improvement	Total Savings & Opportunity £m	2026/27 Ambition £m	Green £m	Amber £m	Red £m
Workforce/Productivity Deployment	11.7	10.3	4.6	0.9	8.6
CHC	7.8	7.8	2.8	0.0	1.1
Length of Stay - Non Elective	39.6	1.6	0.0	0.0	3.9
Grip & Control	8.0	8.9	4.6	0.1	2.4
Medicines Management	8.7	5.8	1.2	0.0	0.3
Planned Care Productivity	7.0	0.0	0.1	0.0	0.0
Procurement	4.0	4.0	2.8	0.2	1.1
Other	9.4	4.1	12.5	0.1	0.9
Total	**96.2**	**42.5**	**28.6**	**1.2**	**18.4**





Savings – Priority Opportunities

A breakdown of the £18.4m of red-rated schemes identified at Month 7, compared with the £9.9m to £12.6m of priority opportunities identified by the external consultant that are being accelerated for delivery by the UHB, is outlined below.

UHB Red Rated savings Plans Themes	Current Year Forecast Red Schemes £'m	PWC Prority Opportunities	PWC Theme
Continuing Healthcare	1.1	£2.3-£4.0m	Continuing Healthcare incl. LD (includes amber schemes)
Facilities and Estates / Service Reconfiguration	0.5	£0.4m	CEF: delivery to control total
Grip and Control	2.4	£1.5m	Specialist Services: TAVI & lymphoma Corporate Executive
Income Generation	0.2		
JCC Target	0.3		
Procurement	1.1	£1.0m	Procurement above target
Reducing Length of Stay (Bed Plan, Winter Bed Closures)	3.9	£2.7m	Medicine: bed plan & winter funding
Value/Clinical Variation	0.1		
Vacancy Holds, Reduction in Bank & Agency	8.6	£2.0m-£3.0m	Workforce
Grand Total £m	**18.3**	£9.9m - £12.6m	



Savings

Further detail of the progress by Clinical Boards against the £42.5m core savings target is provided below:

Business Unit	Target (£'m)	Green (£'m)	Amber (£'m)	Total (£'m)	Shortfall (£'m)
CD&T	4.9	2.8	0.2	**3.0**	**1.9**
Children & Women	7.4	2.7	0.1	**2.9**	**4.5**
Capital, Estates & Facilities	2.9	1.0	0.0	**1.0**	**1.9**
Executives	1.8	0.6	0.0	**0.6**	**1.2**
Genomics	0.0	0.6	0.0	**0.6**	**(0.6)**
Medicine	3.2	4.8	0.6	**5.4**	**(2.2)**
Mental Health	4.0	2.3	0.0	**2.3**	**1.7**
PCIC	3.0	3.7	0.0	**3.7**	**(0.7)**
Specialist	8.0	4.5	0.1	**4.5**	**3.5**
Surgery	6.1	4.4	0.2	**4.6**	**1.5**
Corporate	1.2	1.2	0.0	**1.2**	**0.0**
Total Surplus/Deficit	**42.5**	**28.6**	**1.2**	**29.8**	**12.7**

In addition to the above green and amber confirmed schemes, the latest position now identifies sufficient schemes and pipeline opportunities to cover the core £42.5m savings requirement in full, although a material proportion (£18.4m) remains at red status and is therefore a significant delivery risk. The immediate priority is therefore to move these opportunities through the pipeline, establish clear ownership and implementation milestones, and ensure that the financial impact is evidenced through the monthly position.

The £18.4m red pipeline includes the additional measures agreed by the Executive Team, principally:

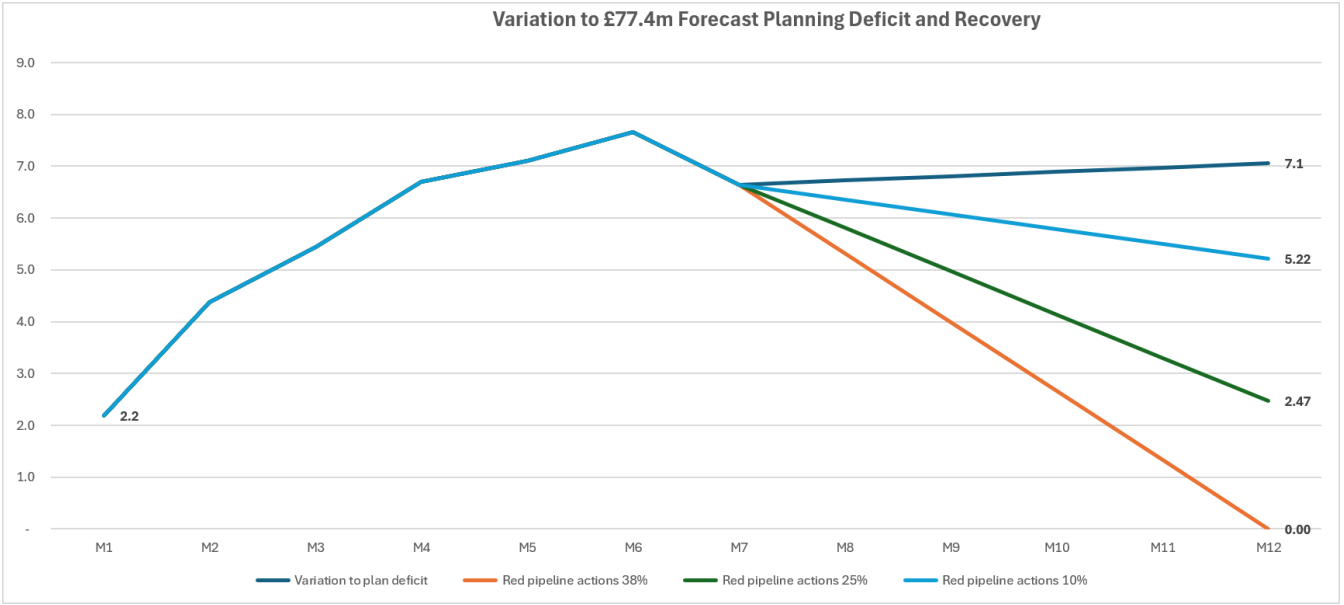
- a 237 WTE vacancy hold, based on retaining 50% of turnover arising between 1 August 2026 and 31 March 2027; and
- a 10% reduction in bank expenditure.
- a 30% agency reduction in line with the national target
- acute bed capacity reduction and remodelling



Financial Recovery

Recovery of the in-year financial position and de-risking the financial Plan:

At month 7 the Health Board's gross forecast before recovery actions is £84.5m. This is £7.1m over and above Welsh Governments expected forecast deficit of £77.4m. **The forecast scenarios include delivery of red pipeline schemes. c38% delivery of red pipeline schemes is required in order to hit the £77.4m revised planning deficit.**





Risks

Below is a summary of UHB Corporate Risk Register at October 2026. Further information of the risks can be found in the risk register:

Finance Risk Title	Rating
Risk to delivering £77.4m revised financial forecast. The UHB must deliver the agreed savings programme target alongside managing operational pressures.	15
Failure to manage recurrent operational/CIP pressures. Deterioration in the recurrent position would result in an increasingly financially unsustainable organisation	20
Achievement of statutory capital breakeven duty. The Health Board should not exceed its capital allocation on a three year rolling basis.	8
Remain within Cash limit. There is a risk that the UHB will require cash support from Welsh Government as a result of the £77.4m revised forecast deficit and movements in working capital.	15
Welsh Risk Pool - Increased Risks Apportionment. There is a risk that the UHBs risk share apportionment will be higher than plan.	6
Welsh Government allocations awaiting confirmation at anticipated values. Material differences to the UHBs current assessment of anticipated allocations could significantly impact the UHBs ability to deliver the £77.4m revised forecast deficit.	12
Financial impact of implementation of new Resident Doctor contract from August 2026. There is a risk of financial implications from the new Resident Doctor contract not currently recognised within the financial plan.	12
LTA Performance JCC & Health Boards. Variance from assumed level of performance presents a risk of lost income due to under performance or inability of commissioners to settle for over performance.	9
Following arbitration, a 2% cost savings programme was mandated by the JCC, resulting in a £5m savings requirement for the Provider (net of the associated Commissioner benefit). There is a risk that failure to deliver these savings could lead to a £5m deterioration in the overall financial position.	15



Forecast Position

Following consideration by the UHB Board, a financial plan, which included a forecast deficit of £86.5m, was submitted to the Welsh Government at the end of March 2026.
The plan identified £7.7m of green and amber savings schemes leaving a gap of £34.8m to the £42.5m target.

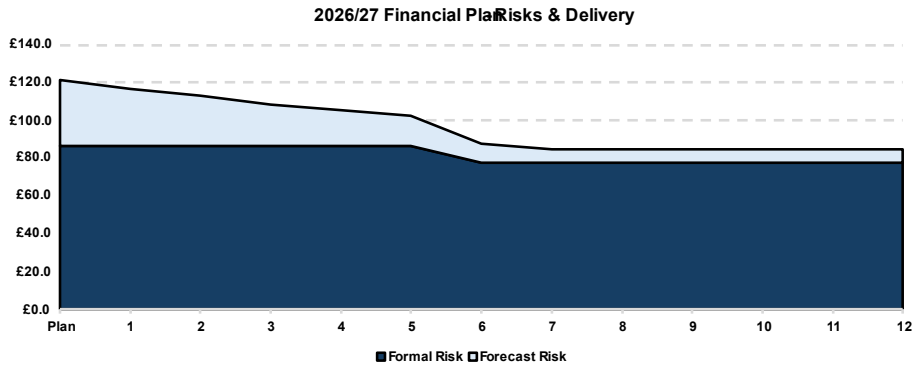
The planned deficit has been reduced from £86.5 million to a forecast deficit of £77.4 million in month, reflecting a £9.1 million reduction in the UHB's expected contribution to the Welsh Risk Pool for 2026/27 confirmed in month 6

At Month 07, the UHB's savings tracker reported a £17.8m shortfall of green and amber schemes against the combined core (£42.5m) and JCC (£5.1m)savings target of £47.6m. A full year operational surplus of £10.7m is forecast.

The resulting £7.1m risk to the achievement of the plan is illustrated below:

Key Forecast Components £m	Plan	1	2	3	4	5	6	7	8	9	10	11	12
Formal Forecast	86.5	86.5	86.5	86.5	86.5	86.5	86.5	86.5	86.5	86.5	86.5	86.5	86.5
WG additional Funding (Reduction in contribution to WRP)	0.0	0.0	0.0	0.0	0.0	0.0	(9.1)	(9.1)	(9.1)	(9.1)	(9.1)	(9.1)	(9.1)
Annual Savings Shortfall	**34.8**	**29.2**	**28.2**	**27.7**	**24.2**	**23.0**	**20.6**	**17.8**	**17.8**	**17.8**	**17.8**	**17.8**	**17.8**
Cumulative Savings Shortfall/ (Surplus)	0.0	29.2	28.2	27.7	24.2	23.0	20.6	17.8	17.8	17.8	17.8	17.8	17.8
Forecast Cumulative Operational Pressures	0.0	0.9	(1.5)	(6.1)	(5.4)	(7.2)	(10.1)	(10.7)	(10.7)	(10.7)	(10.7)	(10.7)	(10.7)
Recovery Actions to be agreed	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Forecast Risk (Health Board gross forecast before recovery actions)	**34.8**	**30.0**	**26.7**	**21.6**	**18.8**	**15.8**	**10.5**	**7.1**	**7.1**	**7.1**	**7.1**	**7.1**	**7.1**

The table below demonstrates the progress in closing forecast risk as the year has progressed.





Underlying Deficit

The UHB's underlying deficit (ULD) has increased in recent years due to recurrent cost pressures, demand growth, and the under-delivery of recurrent savings. The UHB reassessed its planning assumptions for 2026/27 accordingly. The tables below summarise the underlying deficit of £86.5m in the submitted plan.

Planning Assumption	£m
Underlying Deficit (ULD) brought forward	68.8
Demand and cost growth and unavoidable investments	54.7
2026/27 Increase in Contribution to Welsh Risk Pool	21.5
Quality Improvement Programme - savings	(42.5)
Additional Recurrent Allocations	(15.9)
Planned Underlying Deficit (ULD) at end of 2026/27	86.5

The underlying deficit has been re-assessed and revised from £86.5m to £77.4 million, reflecting the assumption that the £9.1m reduction in the UHB's Welsh Risk Pool contribution for 2026/27 represents a recurrent funding benefit. The assessment also assumes the full recurrent delivery of the original 2026/27 Financial Plan and excludes any ongoing impact of current non-recurrent cost pressures, one-off expenditure reductions, or other temporary mitigating actions. The key drivers of the underlying deficit were previously set out to Welsh Government as part of the 2026/27 Financial Plan submission.

If the gap against the recurrent savings plan is not closed the ULD will increase to £102.1m as follows unless mitigating actions are identified and implemented:

Planning Assumption	£m
Underlying Deficit (ULD) brought forward	68.8
Demand and cost growth and unavoidable investments	54.7
2026/27 Increase in Contribution to Welsh Risk Pool	21.5
JCC Efficiency Target	5.1
Quality Improvement Programme - savings	(42.5)
JCC Quality Improvement Programme - savings	(5.1)
Additional Allocations	(15.9)
Planned Underlying Deficit (ULD) at end of 2026/27	86.5
In Year Revision to Contribution to Welsh Risk Pool	(9.1)
Forecast Underlying Deficit (ULD) at end of 2026/27	77.4
Shortfall against Recurrent Core and additional JCC Efficiency Savings Target at month 07	24.7
Forecast Underlying Deficit (ULD) at end of 2026/27 without further identification of Savings & Actions	102.1

Further work is therefore required to identify and implement recurrent savings schemes to close both the core and the additional JCC efficiency savings gap .



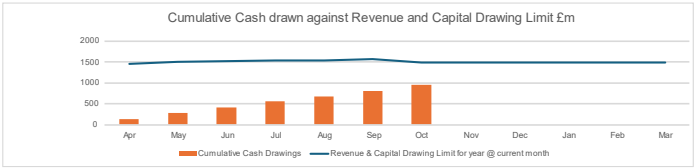
Cash & Allocations

The closing cash balance at the end of October was £4.367m.

The value of unconfirmed drawing and resource limit allocations at month 07 was £52.0m & £98.1m respectively as outlined opposite.

Unconfirmed Drawing and Resource Limit Allocations as of 31st October 2026	Drawing Limit £'m	Resource Limit £'m
26-27 AFC Pay Award	26.6	26.6
26-27 AFC Pay Award Band 3 Compression	0.6	0.6
26-27 M&D Pay Award	8.9	8.9
26-27 M&D Pay Award CU Employed Consultants	0.2	0.2
A2A Sanctuary	0.5	0.5
All Wales International Recruitment	0.0	0.0
ATMPS (JCC)	1.9	1.9
Budvidal - HMP Prison Cardiff Costs	0.2	0.2
Consultant Clinical Excellence Award / Consultant Impact Award	0.8	0.8
Depreciation, Impairments And IFRS 16	(5.0)	47.5
Direct Payments for CHC - Implementation & Funding	0.0	0.0
EPMA Business Case Contingency	0.5	0.5
ESMCP Resources / CRS / MDVS / ARRP	0.1	0.1
ESR & ESR Helpdesk	1.9	1.9
GMS Disp Doctors / PADMS & List Sized Funding	0.3	0.3
GP IM&T Refresh Programme	1.6	1.6
Individual Placement & Support In Primary Care	0.2	0.3
Integration And Rebalancing Capital Fund (IRCF)	0.0	0.0
MH Advocacy Funding	0.3	0.3
Neurodivergence Improvement Programme	1.0	1.0
Planned Care Recovery 2026-27: Funding Allocation Confirmation	16.4	16.4
Planned Care Transformation Fund Optometry Community Pathways	0.1	0.1
Prevention And Early Years	0.8	0.8
Public Health LHBs in Prevention for Gambling Harms	0.0	0.0
Resident Drs Contract additional HEIW TGS 2026 HB enhancements	(0.2)	(0.2)
Revenue Working Balances Request	6.5	
TSW Funding	0.2	0.2
Vertex (JCC)	5.2	5.2
VSM Pay Award	0.1	0.1
Welsh Risk Pool	(18.0)	(18.0)
Womens Health Hubs	0.2	0.2
Total Anticipated Funding £'000s	**52.0**	**98.1**

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



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 96.6% for the year to date.



2026-27 Technical Update 3 issued by the Finance Directorate, Health Social Care and Early Years Group, Welsh Government on the 11th November 2026 confirmed that Health Boards are required to submit an Accountable Officer letter in support of a request for Strategic Cash Support in 2026/27. Application requests must be submitted by Monday 7th December 2026.

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 the Chief Executive NHS Wales.
- All applications are to be approved by the Board prior to submission, including consideration of the cumulative cash support position of the LHB or confirmation of the Board meeting date that the LHBs cash requirement will be discussed.
- An outline of 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 year end cash deficit arising from its forecast deficit in 2026/27 within the monthly monitoring return submitted to Welsh Government. In addition, the Finance Committee has previously been advised that in due course, the UHB expects to seek Finance Committee and Board approval to request £77.4m strategic cash support from Welsh Government to cover the cash shortfall arising from the forecast deficit.

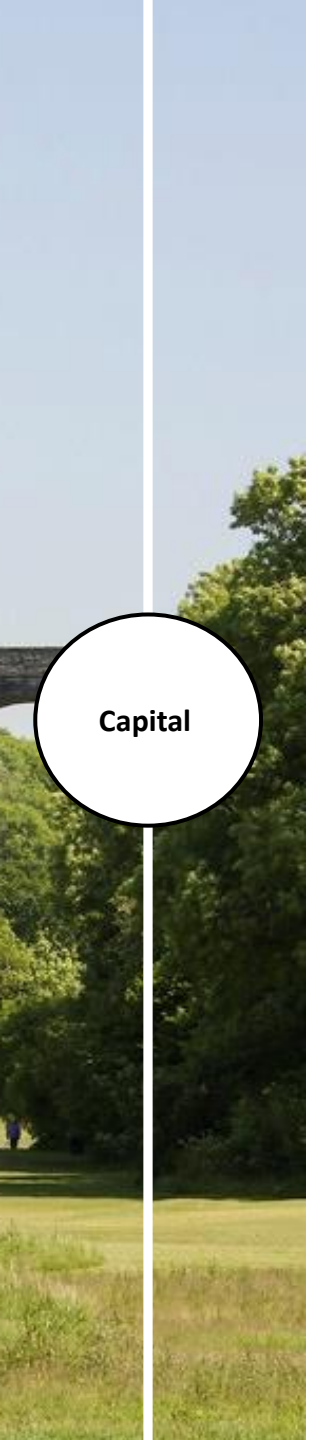
At month 7, the UHB is reporting an overspend of £51.8m and is working to recover the month 7 overspend against the plan to deliver the Revised Forecast Deficit of £77.4m. The UHB continues to manage and strengthen its income recovery processes, ensuring that all income due is collected in a timely manner.

The UHB received strategic cash support of £26.900m in 2022/23, £16.460m in 2023/24m £9.100m in 2024/25 and £16.000m in 2025/26. Therefore, the cumulative cash support position of the LHB will stand at £145.829m if the 2026/27 strategic cash request for £77.369m is approved.

Table 1 - Cumulative Strategic Cash Support

	2022-23 £m	2023-24 £m	2024-25 £m	2025-26 £m	2026-27 £m
Strategic Cash Assistance	26.900	16.460	9.100	16.000	77.369
Cumulative Total £m	**26.900**	**43.360**	**52.460**	**68.460**	**145.829**

In addition to the strategic cash request, the UHB estimates that it requires £18.5m of working cash support to cover in year movement in its revenue and capital working balances since April 2026. 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.



Capital

The UHBs approved Capital Resource Limit issued by Welsh Government as at the 5th November was £40.422m.

This included

- **£16.842m** discretionary funding
- **£23.462m** for specific projects
- **£0.138m** IFRS 16 lease capital funding

The Capital Management Group monitors and approves the UHB's capital expenditure plans.

2026/7 Capital Programme (£m)	M7 Ytd			Plan			CRL	Orders Raised	Orders Receipted
	Actual	Original Plan	Variance	Original	October Review	Variance	05 Nov 26		
All Wales Schemes									
Lift Refurbishment and Upgrade, UHW	0.024	1.150	(1.126)	2.854	1.275	(1.579)	1.275	0.786	0.024
Pentyrch Branch Surgery Development 2024-26	0.405	0.762	(0.357)	0.762	0.762	0.000	0.762	0.762	0.415
Haematology Day Centre Extension, University Hospital of Wales	0.078	0.560	(0.482)	1.089	1.089	0.000	1.089	0.923	0.568
TEF - Fire	0.118	0.246	(0.128)	0.362	0.362	0.000	0.362	0.225	0.122
TEF - Infrastructure	0.004	0.840	(0.836)	2.552	2.552	0.000	2.552	2.285	0.004
TEF - Decarbonisation	(0.000)	0.138	(0.138)	0.329	0.329	0.000	0.329	0.000	0.000
TEF - Mental Health	0.107	0.212	(0.105)	0.261	0.261	0.000	0.261	0.107	0.155
TEF - Infection Prevention Control	0.026	0.248	(0.222)	0.448	0.448	0.000	0.448	0.105	0.026
TEF - Decontamination	0.008	0.149	(0.141)	0.603	0.603	0.000	0.603	0.491	0.008
Transport Hub and Car Park at University Hospital of Wales	0.045	0.386	(0.341)	0.386	0.386	0.000	0.386	0.395	0.045
Diagnostic Investments 2026-27	0.000	1.492	(1.492)	3.731	3.731	0.000	3.731	0.803	0.000
Electrical Infrastructure, Tertiary Tower Block at UHW	0.434	0.832	(0.398)	0.310	0.310	0.000	0.310	0.310	0.425
Estates & Equipment End of Year Funding 2025-26	0.320	0.813	(0.493)	0.813	0.813	0.000	0.813	0.436	0.323
Mental Health Quality and Safety Schemes	0.164	0.388	(0.224)	0.388	0.388	0.000	0.388	0.575	0.164
Hospital Helicopter Landing Site Schemes 2025-26	0.111	0.111	(0.000)	0.111	0.111	0.000	0.111	0.153	0.153
End of Year Funding - January 2026	0.384	0.403	(0.019)	0.649	0.649	0.000	0.649	0.389	0.453
UHW Ward Block Roof Replacement	0.150	1.095	(0.945)	2.258	1.677	(0.581)	1.677	1.388	0.168
Mental Health Quality and Safety Schemes 2026-27	0.000	0.171	(0.171)	0.456	0.456	0.000	0.456	0.000	0.000
Park View Health and Wellbeing Hub	0.007	0.681	(0.674)	5.691	3.000	(2.691)	3.000	0.011	0.007
DPIF - Digital Maternity	0.000	0.000	0.000	0.050	0.050	0.000	0.050	0.000	0.000
Estates Backlog Funding	0.227	0.000	0.227	1.550	1.550	0.000	1.550	0.501	0.005
Digital Backlog Funding	0.000	0.000	0.000	2.320	2.320	0.000	2.320	0.000	0.000
DPIF - Electronic Prescribing and Medicines Administration (ePMA) programme	0.000	0.000	0.000	0.340	0.340	0.000	0.340	0.000	0.000
IFRS16	0.000	0.000	0.000	0.138	0.138	0.000 0.000 0.000	0.000	0.138	0.138
IM&T:	0.392	1.150	(0.758)	3.016	3.016	0.000	1.000	0.459	0.323
Equip	0.252	0.583	(0.331)	1.000	1.000	0.000	1.000	0.367	0.248
Stat comp	1.151	1.111	0.040	2.600	2.600	0.000	2.800	2.506	1.203
Other	1.332	3.444	(2.112)	10.226	10.226	0.000	12.042	3.299	0.841
Total	**5.739**	**16.965**	**(11.226)**	**45.293**	**40.442**	**(4.851)**	**40.304**	**17.412**	**5.818**

requirements. A revised Capital Resource Limit (CRL) was issued on 5 November to reflect the agreed changes to the 2026/27 capital programme.



Conclusion

The UHB's financial plan, incorporating a planned deficit of £86.5 million, was noted by the Board but was not approved by Welsh Government as it did not meet the statutory duty to break even.

Following confirmation in Month 6 of a £9.1 million reduction in the UHB's 2026/27 contribution to the Welsh Risk Pool, Welsh Government has confirmed that it expects the forecast deficit to be reduced from the original planning deficit of £86.5 million to £77.4 million. This amendment reflects an external funding adjustment and does not alter the underlying financial challenges facing the UHB or the requirement to deliver planned savings and expenditure control measures.

At Month 07 the Committee is requested to:

- **NOTE** the reported year to date position is an overspend of £51.8m with a year end forecast deficit of £77.4m.
- **NOTE** There is an urgent need to de-risk the £77.4m revised forecast deficit. There is a £7.1m gap to delivery.
- **NOTE** that at Month 07 there is an adverse variance of £6.6m against the revised forecast, driven by a £10.4m savings deficit, partially offset by an operational surplus of (£3.8m).
- **NOTE** that against the combined £47.6m core (£42.5m) and JCC (£5.1m) savings target, £29.8m of green and amber savings and a further £18.4m of red-rated schemes had been identified by Month 7. While this exceeds the overall target, delivery remains reliant on higher-risk red schemes, increasing the risk of non- achievement.
- **NOTE** that the forecast remains dependent on the delivery of further financial mitigations, with material risks continuing in relation to the savings programme and the recurrent financial position. The Welsh Risk Pool adjustment has been assumed to provide a recurrent benefit to the underlying position.
- **NOTE** there are £98.1m of outstanding resource limit allocations.

- **APPROVE** the UHB's request to Welsh Government for £77.4m of Strategic Cash Support in support of its forecast deficit.
- **RECOMMEND** that the UHB Board approves the submission of an Accountable Officer Letter to Welsh Government requesting £77.369m Strategic Cash Support to fund the cash shortfall arising from the UHB's 2026/27 forecast deficit.

Report Title: *(needs to match agenda)*	CAV Planning Maturity Matrix Self-Assessment 2026		Agenda Item No:		3.1
Meeting:	Finance & Performance Committee	Public	X	Meeting Date:	18/11/2026
		Private			
Lead Executive Title:	Executive Director of Strategic Planning & Partnerships				
Report Author/s Title:	Strategic Planning & Delivery Manager Head of Strategic Planning				

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

ADVISE *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

ASSURE *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

The 2026 Planning Maturity Matrix self-assessment provides evidence of improvement in the UHB's planning capability, with two domains progressing from Level 2 to Level 3 and increases in maturity across several sub-domains whose overall domain ratings remain unchanged. These findings demonstrate stronger foundations for organisational planning, particularly in engagement, regional service design and strategic planning.

Assurance remains qualified, however, by continuing gaps in commissioning, strategy-to-plan alignment and the integration of service, workforce and financial planning. The assessment does not yet demonstrate that the stronger individual capabilities are consistently operating together to support a financially sustainable, approvable and deliverable plan. The proposed improvement actions should begin to address these gaps, with consolidation into four to five priority improvements to be completed before Board consideration.

Board/Committee Response Required ***(please select only one)***

To confirm the action Members are being asked to take considering the AAA Framework

Assurance		**Approval**	X	**Information/Noting**	

Recommendations

Recommendations should be clear, actionable, and aligned to the AAA summary above.

The Committee is requested to:

1. **Endorse** the 2026 Planning Maturity Matrix self-assessment and associated improvement actions and in doing so,
2. **Note** the progress achieved against actions identified within the 2025 assessment and action plan.
3. **Note** that the full evidence pack to support this assessment has not been shared with committee due to its size but is available upon request.

4. **Support** the assessment being submitted to public Board in November for formal approval (a perquisite before submission to Welsh Government).

Governance Route *(please list all other Committee/Groups this report has been to)*	
***Where** it's been:*	*N/A*
***When** it went:*	*N/A*
***What** decision was made:*	*N/A*

Main Report
Background & Current Situation

1. Background & Purpose

Planning remains a critical organisational function, providing the framework through which the Health Board aligns its strategic ambitions, operational priorities and resources to deliver safe, effective and sustainable services.

Cardiff and Vale UHB (CAVUHB) is in level 4 escalation for planning. A deescalation requirement is that the organisation undertakes an annual Planning Maturity Matrix self-assessment and submit the outcome to Welsh Government.

2. Explanation of Assessment Process

The Planning Maturity Matrix assesses organisational capability and maturity across six planning domains. Within each domain there are a series of sub-categories. Each sub-category has to be assessed and scored with an aggregated score than assigned to the whole domain. Scoring takes place from 1-5 with 1 being basic level of maturity and 5 being an exemplar.

Appendix 1 provides a copy of the NHS Wales strategy and planning maturity matrix which sets out the domains and sub-categories in more detail.

The assessment was undertaken using a multidisciplinary approach involving leads from planning, commissioning, finance, operations, partnerships and engagement functions. The assessment is supported by a comprehensive evidence base and identifies current maturity levels, future aspirations and improvement actions.

3. Outcome of the assessment

The full outcome of the UHBs planning maturity assessment can be found in **Appendix 2**.

Table 1 below summarises the UHBs assessment and provides a comparison against 2025 levels.

The 2026 self-assessment presents a broadly similar overall maturity profile to that reported in 2025, with two domains—*Dynamic and Engaged Planning* and *Best Practice Approach to Improvement*—progressing from Level 2 to Level 3.

This is consistent with the position set out in 2025, which recognised that strengthening and embedding organisational planning capability is a multi-year endeavour. However, the headline domain ratings should not obscure the good progress made across many sub-domains, where increases in maturity are evident, including within domains whose overall rating remains unchanged. The assessment therefore demonstrates both the progress achieved and the sustained work required to translate improvements in individual planning capabilities into higher levels of maturity across all domains.

Table 1:

Domain	2025 assessment level	2026 assessment level	
Domain A: Strategy and Plan Development	**2**	**2**	
○ Strategy and Plan	2	3	
○ Vision and Purpose	2	2	
○ Alignment of national policy and all level partnership priorities	2	3	
○ Key enablers	1	1	
○ Engagement and development	2	3	
○ Population health needs assessment	1	2	
○ Priorities and achievability	1	1	
○ Horizon scanning	2	2	
Domain B: Strategy, Plan Alignment & Development of IMTP	**1**	**1**	
○ IMTP development	1	1	
○ Alignment between clinical services strategy and annual plan/IMTP	1	1	
○ Triangulation of services	1	2	
○ Commissioning	1	1	
Domain C: Dynamic and Engaged Planning	**2**	**3**	
○ Stakeholder engagement	2	3	
○ Service delivery risk and issue management	2	3	
○ Service model / regional design	2	3	
Domain D: Operational Planning	**2**	**2**	
○ Demand and capacity modelling	1	2	
○ Clinical leadership input	2	2	
○ Planning process	1	1	
Domain E: Best Practice Approach to Improvement	**2**	**3**	
○ Engagement	3	4	
○ Benchmarking	1	2	
○ Governance	2	2	
Domain F: Realistic and Deliverable	**2**	**2**	
○ Risk identification and management	2	2	
○ Development of IMTP and track record	1	1	
○ Monitoring and Delivery	2	2	

4. Progress in Planning Maturity: Achievements and Remaining Gaps

The 2025 assessment set out 50 actions for delivery.

26 of 50 actions (52%) were completed and 10 (20%) closed. Twelve actions (24%) have been carried forward as priorities for 2026/27, with one further action in progress and one not started / on hold.

The principal progress since the 2025 assessment is however not in judging the blunt number of actions that have, or have not, been completed but in, for example, strengthening the strategic direction, engagement and collaborative arrangements that underpin effective organisational planning.

Approval and mobilisation of the Clinical Services Plan, continued implementation of *Shaping Our Future Wellbeing*, strengthened regional planning through the South East Wales Regional Joint Committee, and development of commissioning intentions provide a stronger foundation for future planning decisions. Their significance lies not simply in the completion of individual milestones, but in creating clearer mechanisms through which strategic ambitions, service requirements and partner priorities can be considered together.

The pattern of maturity scores nevertheless demonstrates that progress is neither uniform nor confined to the two domains whose overall ratings have increased.

"Dynamic and Engaged Planning" has progressed across all three of its sub-domains, indicating a broader strengthening of engagement, service delivery risk management and regional service design. Within "Best Practice Approach to Improvement", engagement has advanced to Level 4 and benchmarking to Level 2, although governance remains at Level 2. Improvements in strategy and plan development, alignment with national and partnership priorities, population health needs assessment, service triangulation, and demand and capacity modelling also demonstrate material progress within domains whose overall ratings remain unchanged.

The central distinction emerging from the assessment is between strengthening individual planning capabilities and demonstrating that these are consistently embedded within an integrated organisational planning process. Approval and subsequent mobilisation of the Clinical Services Plan has established a clearer strategic direction, while work undertaken through the IIP has subsequently strengthened the connection between the Clinical Services Plan and organisational delivery priorities. This represents important progress since the point at which the assessment was undertaken. However, the formal assessment of alignment between the clinical services strategy and the annual plan/IMTP remains at Level 1, reflecting the evidence available at the time of assessment and the need to demonstrate that this stronger alignment is consistently embedded through future planning cycles. Similarly, development of commissioning intentions is an important step towards a more explicit commissioning approach, but commissioning maturity remains at Level 1. These positions are not contradictory- they indicate that important foundations have been established, while further evidence is required that they are routinely shaping priorities, resource decisions and delivery commitments.

The assessment also highlights the importance of distinguishing improvements in arrangements from demonstrated improvements in deliverability.

Enhanced monitoring, oversight and risk management provide mechanisms to support delivery, but have not yet resulted in higher maturity ratings within the "Realistic and Deliverable" domain. Key enablers, priorities and achievability, and the planning process also remain at Level 1. Taken together, these findings suggest that the next stage of development must place greater emphasis on how service ambitions are reconciled with workforce, financial and operational capacity, and how the resulting choices are translated into credible plans and sustained delivery.

Progress against the 2025 improvement actions should therefore be judged not only by whether a strategy, process or governance arrangement has been established, but by the extent to which it is embedded and demonstrably influencing organisational decisions. The continuing requirement to produce a financially sustainable and approvable medium-term plan remains central. However, the assessment identifies capability gaps that require attention in their own right; financial sustainability should not be treated as the sole explanation for the remaining maturity constraints.

Overall, the assessment demonstrates meaningful but incomplete progress and provides a clear rationale for the improvement priorities set out in Section 5 below.

5. Actions for 2026/27

58 actions for the UHB to progress have been identified in the assessment.
The proposed development of commissioning capability, greater integration of workforce, finance and operational planning, stronger population health-informed prioritisation, and an organisation-wide performance management and integrated improvement planning approach are some of the most material and align with the principal gaps identified in section four.

Collectively, these actions will seek to move the UHB from strengthening individual components of planning to embedding their consistent use in organisational decision-making and delivery.

The next test of maturity will therefore be not simply whether these arrangements are established, but whether they demonstrably improve the alignment of strategy, priorities and resources, support a sustainable and approvable plan, and strengthen delivery against agreed commitments.

6. Lessons Learned During 2025/26

The second annual assessment has highlighted two lessons for taking into the next year of delivery;

- The assessment can generate overlapping actions across domains. These should be consolidated at the outset to remove duplication and establish a coherent set of improvement commitments, avoiding the need to close duplicate actions during the year.

- The scale of the resulting action plan must be considered alongside the organisation's capacity to deliver. Even after duplication is removed, a lengthy action plan risks dispersing effort across too many commitments. The UHB should therefore identify four to five priority improvements with the greatest potential to strengthen planning capability and demonstrate meaningful change. This exercise will be undertaken before the assessment is presented to the Board in November.

7. Future Challenges and Areas for Development

Two principle challenges exist in successfully executing next years actions and these must be considered when progress is actively tracked in the coming twelve months;

- Strengthening planning maturity requires organisation-wide ownership. The assessment considers the UHB's collective capability to develop and deliver integrated plans; it is not solely an assessment of the planning function. Responsibility for progressing the resulting improvement actions must therefore be shared across the relevant clinical, operational and corporate functions, rather than treated as a planning-led action plan alone.

- Delivery of some improvement actions depends on wider organisational decisions, including those relating to organisational design and the future focus of the UHB's corporate performance function. These dependencies will need to be reflected in the sequencing and timescales of the improvement programme, recognising that some

actions cannot be fully implemented until the necessary foundational decisions have been taken.

Appendices:
(List any appendices that will accompany this report).

Appendix 1: NHS Wales strategy and planning maturity matrix
Appendix 2: CAVUHB Planning Maturity 2026 Assessment

Strategic Alignment – Shaping Our Future Wellbeing:

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

Impact Assessment *Please ensure each section is completed. (If "Yes" is selected, complete the detail. If "No", please write "Not applicable".)*
Risk: No
Not applicable.
Safety: No
Not applicable.
Financial: No
Not applicable.
Workforce: No
Not applicable.
Legal: No
Not applicable.
Reputational: No
Not applicable.
Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*
Not applicable.
Equality & Health: No
Not applicable.
Decarbonisation: No
Not applicable.
Welsh Language: No
Not applicable.

NHS Wales

Strategy and Planning Maturity Matrix

The NHS Wales Planning Maturity Matrix has been reviewed and updated in September 2025. The Matrix contains 6 domains and as listed below. Within each domain, themes have been created from the elements within the previous matrix. These themes have been made progressive and are progressed through the 5 levels of maturity.

The 6 Domains and their descriptors are:

Domain	Description
A) Strategy Development/Clarity of Purpose, Vision and Strategy	• Evidence of a clear purpose, vision and strategy for the organisation. • Responds to national, regional, local and partnership priorities, and the wider determinants of health. • Translates national policies into local strategy, planning, and delivery.
B) Strategy Alignment and Development of an IMTP	• Evidence of alignment of strategy with components of the plan.
C) Dynamic and Engaged Planning	• Reflecting a dynamic, engaged and ongoing approach to planning. Process is positively influencing outcomes. • Organisation identifies fragile services and has plans in place to address / mitigate risks and proposals in place for more robust service models e.g. via regional solutions, consolidation of services etc.
D) Operational Planning	• Evidence of demand and capacity planning, linking to triangulation of operational plans, workforce and finance. • Embedding a culture of reducing unwarranted variation, improved performance and outcomes end evaluation of improvements
E) Best Practice Approach to Improvement	• Ambition to deliver best practice levels of equity, efficiency, effectiveness, quality and safety.
F) Realistic and Deliverable:	• Sensitivity analyses, risk assessment of deliverability, reference to track record of delivery. Sustainable and affordable.

A) Strategy Development/ Clarity of Purpose, Vision and Strategy Plan					
	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 Alignment and Development of an IMTP					
	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

	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	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.

				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					
	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					
	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

	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

Domain	Subcategory	Action ID	Actions	Deadline	Status	Lead	Evidence	Notes
A) Strategy and Plan Development	Strategy and Plan	ID 1	1. Executive steering group (ESG) whole day session to set the strategic priorities that will guide the 26/27 planning cycle	Q3 25-26	Complete	Programme Director Clinical Services	ME meeting notes / presentation Board Dev day pack inc the baseline assessment work undertaken by the organisation	Whilst a whole day ESG session was not held a number of Executive team meetings had dedicated ring-fenced time to discuss and shape 27-28 priorities- these were also influenced and shaped via a 2hr dedicated session with Board via a Board Dev day
		ID 2	2. Board approved CSP	Q4 25-26	Complete	Programme Director Clinical Services	Board approved CSP	
		ID 3	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 25-26	Complete	Programme Director Clinical Services Head of Strategic Planning	Report from Feb strategy day and annual plan priority actions supplementary pack	
	Vision and Purpose	ID 4	1. Executive SROs to hold first Portfolio Boards and agree scope and terms of reference (ToR)	Q3 25-26	Complete	Programme Director Clinical Services Head of Strategic Planning	ToR for portfolios	
		ID 5	2. Board Development Session to discuss strategic portfolios progress and agree a process for regular board reporting	Q3 25-26	Complete	Programme Director Clinical Services Head of Strategic Planning	Board reports and BAF	
		ID 6	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	Q3 25-27	Complete	Programme Director Clinical Services Head of Strategic Planning	As above, captured in above action (twice yearly) August Board Development day also now has a dedicated focus on strategy / planning with Board discussions on strategy/ annual plan / IMTP / progress etc	
		ID 7	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	Q3 25-26	Closed	Programme Director Clinical Services Head of Strategic Planning		This is a repeat of action ID
	Alignement of National Policy and All-Level partnerships priorities	ID 8	1. National and regional priorities are reflected within our CSP and our IMTP - SEW and RPB	Q4 25-26	Complete	Programme Director Clinical Services Head of Strategic Planning	CSP - will be included in subsequent roadmap	
	Key enablers	ID 9	1. Set out implications for key enablers within the CSP	Q4 25-26	Complete	Programme Director Clinical Services Head of Strategic Planning	CSP	
	Engagement in Development	ID 10	1. Execute 20-week assessment plan for the CSP	Q3 25-26	Complete	Head of Strategic Planning	Assessment report	
	Population Health Needs Assessment	ID 11	2. Internal workshops to be held to develop CSP_1. staff assessment	Q3 25-26	Complete	Head of Strategic Planning	Assessment report	
		ID 12	1. To be an active partner in the current PNA assessment	Q4 25-26	Complete	Consultant in Public Health	there has been a steering group for PNA in place of which pop health and uhb as whole are actively involved.	
		ID 13	1. Be an active partner in the current PNA exercise	Q4 25-26	Closed	Programme Director Clinical Services		*Repeat of Action ID 12
	Priorities and Achievability	ID 14	2. Deliver an acceptable Annual Plan	Q4 25-27	Closed	Head of Strategic Planning		This is the sum of many other actions being progressed and successfully delivered- it is not and should never have been an action which sits in isolation.
		ID 15	3. Director of Commissioning/ taking up post	Q1 26-27	Complete	Programme Director Clinical Services	DoP started in April 2026- Adam Roberts	
	Horizon Scanning	ID 16	1. Ensure that assessment of horizon scanning is embedded in executive away days twice yearly	Ongoing	In progress - Key priority for 2026-27	Programme Director Clinical Services	Horizon scanning report used to support CSP, needs to become more detailed and systematic beyond the CSP	
		ID 17	2. Horizon scanning assessment against developing strategic plans at portfolio board meetings	Ongoing	In progress - Key priority for 2026-27	Programme Director Clinical Services		
B) Strategy, Plan Alignment and Development of IMTP	IMTP development	ID 18	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 25-26	Complete	Head of Strategic Planning	26-27 Annual Plan & mapping exercise evidence link between ask n's response	26-27 Annual Plan draws clear alignment to the themes / requirements of the planning framework.
	Alignement between Clinical Services Strategy and Plan and the IMTP or Annual Plan	ID 19	1. Develop appropriate delivery and planning mechanisms ensuring alignment between the CSS and annual plan delivery 26/27 and beyond	ongoing	In progress - Key priority for 2026-27	Head of Strategic Planning		
	Triangulation of Services	ID 20	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	Ongoing	In progress - Key priority for 2026-27	Director of Operational Planning and Performance		
		ID 21	2. Further improve consistency between workforce and finance data systems	Ongoing	In progress - Key priority for 2026-27	Director of Operational Planning and Performance		
		ID 22	3. Ensure approved priorities are underpinned by translated detailed plans		Closed	Director of Operational Planning and Performance		This represents a duplication of action IDs 20 & 22
		ID 23	4. Hold internal planning events in Q1/25-26] with Clinical Boards to triangulate workforce, finance, and operations data, informing the development of the 2026/27 Annual Plan	Ongoing	Complete	Director of Operational Planning and Performance	Targeted CB sessions in Oct, Nov & Dec 2025	
	Commissioning	ID 24	1. Appoint a Director of Commissioning	Q3 25-26	Complete	Director of Commissioning	DoC started April 2026 - Ms Emma Ince	
		ID 25	2. Subject to appointment, seek to develop a strategic approach for the UHB to discipline commissioning and planning	Q1 26-27	In Progress - Key priority for 2026-27	Director of Commissioning		
C) Dynamic and Engaged Planning	Stakeholder engagement	ID 26	1. Create an integrated impact assessment (IIA) with a lead expert and governance process in place to sign off each impact assessment	Q4 25-26	closed	Head of Strategic Partnerships and Engagement		due to the implementation of the Health Impact Assessment we have decided to pause our development of an Integrated Impact Assessment.
		ID 27	2. Execute 20-week assessment plan for the CSP	Q3 25-26	Closed	Head of Strategic Partnerships and Engagement		Repeat of action ID 11
	Service Delivery Risk and Issue management approach	ID 28	1. Continue the expansion of AMaT so that all organisation risk registers are consistent, visible and able to comprehensively be reviewed	Q4 25-26	Complete	Director of Operational Planning and Performance	AMAT	All UHB risks are now available within the risk module on AMAT. This currently consists of just shy of 1,500 risks across the entire UHB. These risks are able to be comprehensively reviewed and data can be extracted from the system to assist with Risk management and moderation discussions.
		ID 29	2. Yearly update of fragile services	Q4 25-26	In progress	Programme Director Clinical Services		baseline assessment for all specialist services almost complete. This informs our joint working with Swansea Bay and provider discussions with ICC and other commissioners. For other non-specialised services regional discussions are in progress with a focus on a regional clinical service plan to identify fragile services (predominantly secondary care)
		ID 30	3. Continued engagement with ICC on fragile specialist services	Q4 25-26	Complete	Programme Director Clinical Services	Baseline assessment (see action ID 29)	Whilst this work will always be ongoing the action relates to our baseline assessment (see action ID 29). UHB been proactive in enagagement with the ICC
		ID 31	4. Inclusion of fragile services review as part of Clinical Board Executive Reviews	Q4 25-26	not started / on hold	Programme Director Clinical Services		Exec reviews have been raised as an issue in the independent assessors report and with a new CEO and organisational redesign impending Clinical Board reviews will very likely change.
	Service Model redesign	ID 32	1. Increase pace with shared estate across RPB partners	Q3 26-27	Complete	Programme Director Clinical Services Head of Strategic Planning	(i) Utilised Partnership Asset Mgt Board (PAMB) effectively to agree the strategic approach to a childrens respite center (ii) Matured the internal Health Community Estate (HCE) meeting to drive quicker and more robust decisions on joint opportunities	Whilst the nature of this action is continual what we have achieved over the last 12 months evidences an effort to move with greater pace on joint estates opportunities -
		ID 33	2. Embed the regional JC and establish its remit	Q3 26-27	Complete	Programme Director Clinical Services Head of Strategic Planning	Evidence through clinical services portfolio and RJC ToR through board and signed off	
D) Operational Planning	Demand and Capacity Modelling	ID 34	1. Expand the demand and capacity to include urgent and emergency care	Q4 26-27	In progress - Key priority for 2026-27	Director of Operational Planning and Performance		
		ID 35	2. Develop, resource and implement organisational approach to modelling and forecasting and alignment with medium and long term resource planning (workforce and finance)	Q3 25-26	In progress - Key priority for 2026-27	Director of Operational Planning and Performance		
		ID 36	3. Improve the minimum data set at directorate level		Closed	Director of Operational Planning and Performance		Duplication with ID 21
	Clinical Leadership and Input	ID 37	1. Ensure that clinical leadership is reflected in the CSP through including outputs from SLT workshops	Q4 25-26	Complete	Director of Operational Planning and Performance		
	Planning Process	ID 38	1. Undertake resource mapping exercise against the 26-27 Annual Plan - cross reference with Operational Planning to clarify roles and responsibilities		Closed	Director of Operational Planning and Performance		Superseded by organisational re-design
		ID 39	2. Undertake a review of our operating model for planning in the organisation- including assessment of capacity and capability (once director in post)	Q3 26-27	In Progress: Key priority for 2026-27	Director of Operational Planning and Performance		
E) Best Practice Approach to Improvement	Engagement	ID 40	1. Further develop Planners Collaborative to share best practice, develop culture for planning and to provide support to all levels of the organisation	Q3 25-26	Complete	Programme Director Clinical Services		Whilst the nature of this action is continual what we have achieved over the last 12 months evidences a material progress has been made that this can in its current guise can be considered complete.
		ID 41	2. Build on the relationships created through the engagement process of the CSP to further support future and continuous engagement	Q3 25-26	Complete	Head of Strategic Partnerships and Engagement	our new approach to SRG has been finalised and rebranded as the "Shaping our Future Wellbeing Collaborative", first meeting 14th September.	
		ID 42	3. Monthly meetings with the Shaping Change lead for insight to further inform the engagement data	Q3 25-26	Complete	Head of Strategic Partnerships and Engagement	Minutes of meetings	links made with head of insight and a number of meetings held now meet when required to share information.
		ID 43	4. Development of a central point to store all engagement activity and data - organisational wide	Q4 25-26	Complete	Head of Strategic Partnerships and Engagement	Central repository of bank of knowledge	we now have a bank of knowledge from our CSP engagement and now continually store engagement work in a central place to share information with colleagues.
	Benchmarking	ID 44	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	Q3 25-26	Complete	Director of Operational Planning and Performance Value in Health Programme Manager	Value 25-26 Plan	
		ID 45	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	Q3 25-26	Complete	Director of Operational Planning and Performance Value in Health Programme Manager	Value Impact Tracker	
		ID 46	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 CAV UHB Value Programme Annual Plan	Q3 25-26	In progress: Key priority for 2026-27	Director of Operational Planning and Performance Value in Health Programme Manager		We will continue to progress this action from our 2025 submission where capacity allows - programmes are now in in place for heart failure and diabetes whilst further work has also taken place in arthroplasty linked to our regional work with partners.
		ID 47	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	Q3 25-26	Key priority for 2026-27	Director of Operational Planning and Performance Value in Health Programme Manager		
	Governance	ID 48	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 25-26	In Progress: Key priority for 2026-27	Head of Strategic Planning		
F) Realistic and Deliverable	Risk identification and management	ID 49	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	In Progress: Key priority for 2026-27	Head of Strategic Planning		
	Development of IMTP and track record	ID 50	1. Development of a credible 26/27 annual plan	Q4 25-26	Closed	Head of Strategic Planning		Repeat of action ID 15
	Monitoring and delivery	ID 51	1. Start shifting to outcomes focus strategic framework	Q3 25-26	Closed	Head of Strategic Planning		Repeat of action ID 8
		ID 52	2. Develop mechanisms to ensure IMTP delivery is tracked at Senior leadership Board (SLT) and Clinical Board level	Q1 26-27	Closed	Head of Strategic Planning		Repeat of action ID 50

End of year summary	
Action status	**Number of actions**
Completed	26
Ongoing key priority action rolled forward	12
Closed (see notes section for rationale)	10
Other actions in progress	1
Not started / on hold	1
Total	**50**

A. Strategy Development, Clarity of Purpose, Vision and Strategy Plan

2026 level: 2
2027 level: 2

Subcategory	2025 Subcategory Level	2026 Subcategory Level	Evidence used to assess 2026 level	Supporting Narrative	Action (s)	Deadline	Lead	Evidence to be used	Impact Measurement
1.Strategy and Plan	3	3	A1.1 Shaping Our Future Wellbeing Strategy A1.2 Clinical Services Plan A1.3 CSP Public Engagement Report - March 2026 A1.4 CSP Colleague & Partner Engagement Report - March 2026 A1.5 Integrated Performance Reporting Presentation - June 2026	Our assessment is that the UHB has progressed positively and is now closer to L4 than it was 12 months ago but remains in the upper quartile of L3 as at Nov '26. This is reflected through Board approval of the UHBs Clinical Services Plan (CSP) and the development of the 27/28 annual plan which will be is closely aligned. An approach to service planning has been developed awaiting executive review and sign off on 5th November 2026. The process commences with a baseline assessment of services which is intended to be undertaken during Q3. More work required in ensuring *"Organisation actively identifies risks and opportunities, outcomes are regularly monitored, and planning is informed by data, horizon scanning, and cross-functional collaboration"* to move the UHB into L4. Identified actions seek to address this.	1. Deliver a recovery Integrated Improvement Plan (IIP) for 26/27, with delivery being actively monitored and routinely reported to board. 2. Further develop the IIP ready for monitoring the 27/28 Annual Plan. 3. Have refreshed and approved and UHB Integrated Performance Framework (IPF). The culmination of which will ensure that all priorities have measurable outcomes, named owners and milestones, with risks, opportunities and performance reviewed routinely using available organisational data.	Q3 Q4 Q4	Victoria Le Grys/ Emma Ince Victoria Le Grys/ Emma Ince Victoria Le Grys/ Emma Ince	1. Board-approved Recovery Integrated Improvement Plan for 26/27; 2. Integrated Improvement Plan for 27/28 3. Integrated Performance Framework; Clinical Board performance reports and minimum datasets; senior leadership and Board papers evidencing routine review of outcomes, risks and opportunities; decision logs demonstrating agreed corrective actions and follow-up.	100% of priorities have measurable outcomes, named owners and milestones within the Integrated Improvement Plan. Performance, risks and opportunities are reviewed at least quarterly, with underperformance resulting in documented corrective action and follow-up.
2. Vision and Purpose	2	2	A2.1 Shaping Our Future Wellbeing Strategy A2.2 26-27 Annual Plan A2.3 Strategic Planning, Commissioning and Partnership Board Report - July 2026 A2.4 Strategic Planning, Commissioning and Partnership Board Report - September 2026	The UHB has progressed positively but remains in the upper quartile of L2 as at Nov '26. This is reflected through Board approval of the UHBs CSP which aligns and reiterates the organisations vision and purpose and has informed clearly the commissioning intentions that are informing the development of the 27/28 annual plan. The development of the 26/27 annual plan also sought to draw close alignment to the milestone activities required to realise the organisations vision. More work required in ensuring the *"Organisation demonstrates proactive leadership at Executive and Board level"* and *"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"* to move the UHB into L3 and towards 44. Identified actions seek to address this.	1. Review of senior leadership forums internally within the UHB to ensure there is consistent oversight, discussion and review of strategy and vision. 2. Board debate scheduled more regularly to move beyond the historic provision of dedicated time in August Board development sessions to consider organisational purpose, vision and strategy more consistently. 3. Continued development of more of an outcomes based approach (including intermediate outcome indicators to credibly predict progress to strategy delivery) to planning to enable a clearer line of sight between strategy and delivery through the annual planning process for 27/28.	Q4 Q4 Q4	Adam Roberts Adam Roberts Victoria Le Grys	1. Senior leadership forums agendas demonstrating consistent strategy discussions. 2. Board and Board development agendas demonstrating consistent strategy discussions. 3. Development of an annual plan and aligned integrated improvement plan that progressively provides assurance on outcomes	Strategy, vision and purpose are considered at least quarterly by senior leadership and at least twice yearly by the Board; 100% of organisational priorities aligned to the strategy are mapped to measurable outcomes in the Integrated Improvement Plan, with identified risks and corrective actions routinely tracked.
3. Alignment of National Policy and All-Level Partnership Priorities	2	3	A3.01 Shaping Our Future Wellbeing Strategy A3.02 Clinical Services Plan (CSP) A3.03 26-27 Annual Plan A3.04 Approved Terms of Reference for the Regional Joint Committee (RJC) A3.05 Tertiary Services Development Group Prioritisation Framework A3.06 CAV Velindre Executive Partnership Group Terms of Reference A3.07 Regional and Specialised Services Provider Planning Partnership SOP A3.08 Regional and Specialised Services Provider Planning Forum - Memorandum of Understanding A3.09 Tertiary Services Development Group - SOP A3.10 CAV RPB 5 Year Joint Area Plan, 2023-28 A3.11 CAV RPB Annual Delivery Plan 26-27 A3.12 Community by Design Terms of Reference A3.13 Community by Design Programme Brief A3.14 CAV RPB Terms of Reference A3.15 CAV RPB Population Needs Assessment A3.16 CAV RPB Market Stability Report 2022-27	The agreed Shaping Our Future Wellbeing Strategy and approved CSP align national policy, regional priorities and local population needs, providing a clear framework for service planning and delivery and developed through strong partnership co production. CSP priorities have directly informed the commissioning intentions set out in the 27/28 planning process through which the organisation is developing its plans in response. The development of the CSP has further strengthened the translation of national policy into deliverable service transformation programmes. Governance arrangements provide oversight and assurance that national priorities are reflected within organisational and partnership plans, with progress monitored through established partnership forums and planning structures. The principles of the Well-being of Future Generations (Wales) Act and A Healthier Wales are embedded throughout organisational planning processes and are evident in teh CSP and annual planning process, supporting a focus on prevention, population health, reducing inequalities, integration and long-term sustainability. Partnership working has been strengthened through the South East Wales Regional Joint Committee (RJC), the Regional Specialised Provider Planning Partnership with SBUHB and formalised provider planning with Velindre University NHS Trust and the CAV Region! Partnership Board (RPB). The RPB has three overarching priorities or 'north stars' agreed by all partners in response to AHW: Development of the C&V Integrated Community Care System, First 1000 Days, and Digital Care Region programme. These are articulated in the Joint Area Plan and Annual Delivery Plans, cross-referenced in the 26/27 Annual Plan and are evident in the 27/28 planning priorities. The underpinning governance structures support the alignment of priorities and facilitate joint planning and delivery across organisations. Through these arrangements, strategic priorities for tertiary, specialised, regional and local services are considered, ensuring service developments are aligned with national policy requirements, population need and workforce sustainability considerations.	1. Embed the 5 ways of working of the WBFG Act into core planning processes 2. Joint narrative approved via the RJC and included within respective 27/28 plans demonstrating strategic alignment to RJC agreed priorities. 3. Make demonstrable progress toward a SEW Regional Clinical Services Plan including delivery of a baseline assessment, population needs assessment and development of priorities. 4. Specialised provider baseline assessments completed and priority service list identified across SBUHB and CAVUHB, assessments fed into NWJCC annual planning process and strategy development. 5. Agree and include a common narrative to go in the CAVUHB, Cardiff Council and Vale of Glamorgan Council annual plan and Corporate 27/28 plans demonstrating strategic alignment to RPB agreed priorities. 6. Strategic plans reflect agreed RPB partnership priorities and utilise the evidence from the Population Needs Assessment and Market Stability Reports.	Q4 Q4 Q4 Q3 Q4 Q4	Katie Innes Joanne Hill / Katie Innes Joanne Hill / Katie Innes Joanne Hill / Katie Innes Cath Doman Cath Doman	Annual plan quarterly updates; RSSPPP, RJC, RPB, Velindre partnership papers, minutes and decision logs; annual plan and relevant partnership plans and benefits-realisation reports demonstrating progress against service population health, inequalities and sustainability outcomes; Shaping Our Future Wellbeing Collaborative papers and minutes; Strategic planning updates to board.	Delivery of priorities within the Clinical Services Plan demonstrated through the annual plan quarterly reports Evidence of Well-being of Future Generations Act and A Healthier Wales principles embedded in planning and service redesign. Improved partnership engagement influencing planning and delivery. Improved joint planning and delivery with regional and specialised service partners. Effective oversight demonstrated through formalised partnership forums. Evidence that tertiary and specialised service developments support national strategic priorities and service sustainability. Delivery of CVRPB Annual Delivery Plan, evidenced through quarterly reports and annual report.
4. Key enablers	1	1	A4.1 Clinical Services Plan (CSP) A4.2 Annual Plan Development Group (APDG) Terms of Reference A4.3 Health Community Estates Terms of Reference A4.4 Digital Foundations Programme Business Case Slide Dec A4.5 People & Culture Strategic Plan Refresh 2026-2030: Progress Update A4.6 RPB Capital Coordination Group Terms of Reference A4.7 RPB Regional Commissioning Board Terms of Reference A4.8 RPB Regional Digital Board Terms of Reference	The UHB continues to recognise that several enablers are pivotal in allowing the UHB to plan realistically, align supporting strategies, and avoid delays or gaps in implementation. The UHB has progressed positively and is now in the upper quartile of L1 as at Nov '26 but not yet firmly in a position to assess itself as L2. Progress is reflected through Board approval of the UHBs CSP which sets out key enablers and demonstrated through the 26/27 annual plan and early development of the 27/28 annual plan. The development of a number of strategic plans including the People and Culture Plan and estates infrastructure plans are also progressing with the People and Culture Plan refresh due for completion in January 2027. As part of the 27/28 plan development a new group (Annual Plan Development Group, APDG) has been formally established with the aim of securing greater alignment in planning across key enabling functions. Nevertheless, more work required in to ensure *"Quality expectations are defined, and initial steps taken to coordinate enabler contributions across programmes"*. Partnerships including both the SEW RJC and the RPB have established partnership fora to plan and deliver joint approaches to workforce, capital, digital and commissioning and are fully integrated into planning as evidence by the RJC workplan and the RPB Joint Area Plan, Annual Delivery Plans and Annual Report. Increasingly the UHB recognises the value driven through working with partners to deliver the key enablers.	1. Establish effective engagement and planning with key corporate functions as part of phase 4 of the UHB annual planning process to ensure effective assessesment of clinical board and strategic programme plans to ensure appropriate engagement / alignment and that delivery assumptions are confirmed/validated. 2. A single transformation portfolio has been established replacing existant strategic portfolios to ensure line of sight to enablers and critical dependencies across population health, service redesign and enabling programmes such as acute and community estates, digital, people and culture - TBC after 26th Oct 3. Continue to strengthen joint working with partners around data, digital, estates, workforce and commissioning as mechanisms to deliver the CSP.	Q3 TBC Q4	Jon Watts Vicky Le Grys Cath Doman/ Joanne Hill	1. 27/28 approach to planning report - produced by corporate enabling functions assessing alignment between Clinical Board plan and enabling functions. 2. Transformation portfolio board report and Board minutes. 3. 27/28 Partnership Plans (RPB & SEW) to be reflected in 27/28 UHB annual plan	100% of Clinical Board plans are assessed for opportunties for joint delivery with partners where appropriate

5. Engagement in Development	2	3	A5.1 CSP Public Engagement Report - March 2026 A5.2 CSP Colleague & Partner Engagement Report - March 2026 A5.3 Strategic Planning, Commissioning and Partnership Board Report - July 2026 A5.4 18 month CSP Launch Colleagues (staff and partners) Engagement Plan A5.5 Community by Design Comms and Engagement Plan	Completion of a 20-week public engagement period and 12-week staff engagement for the CSP which was supported by Llais, WG and Wellbeing of Future Generations Commissioner. An 18 month plan has been approved to continue public, partner and colleague engagement on CSP implementation and what that means for them aligning to the 27/28 annual plan and associated transformation programme plans for engagement and communication (inc programmes such as SEW Regional programmes, Community by Design and others).	1. Continued engagement with communities, partnership forums and staff forums to continue messaging the importance of the CSP and delivery against agreed priorities. 2. The newly formed Shaping our Future Wellbeing Collaborative is the predominant vehicle to ensure we keep engaging effectively. 3. Development of an annual plan comms and engagement strategy.	Q4 Q4 Q4	Sarah Tipping Sarah Tipping Sarah Tipping / Jonathan Watts	1. Shaping our Future Wellbeing Collaborative annual report 26/27 2. Strategic Planning Board reports 3. Annual Plan Comms & Engagement Strategy document	SOFW collaborative, Llais and Board feedback on assurance of public, partner and staff engagement in plans and service changes.
6. Population Health Needs Assessment	1	2	A6.1 27-28 Baseline Assessment A6.2 PNA Highlight Report	The UHB continues to recognise that a gap remains between insights generated through formal Population Needs Assessments (PNA) (which are statutory obligations) and their systematic application in informing priorities within strategic planning processses. Completing a formal PNA with partners is a statutory duty - an exercise which is not required to be refreshed and finalised in the last 12 months. Despite this the UHB has made notable progress in this area over the last 12 months which sees it now assess itself at L2. Through a revised 27/28 approach to planning the organisation developed a baseline assessment of its current services and population needs. This was considered by Board and has begun to shape the priorities and commissioning intentions for the next annual plan. As per the wording of L2 we recognise at this stage this is a "basic high level population health needs assessment". This is a starting point with this approach needing to mature to support a move to L3. As completing the PNA is a statutory duty, the UHB remains of the view that the wording of Levels 4 & 5 still require further clarifications as all PNAs are driven by and signed off by the Regional Partnership Board by statute. We suggest that this subcategory be considered for refinement ahead of the next self-assessment exercise. Alongside the statutory PNA, the UHB has commenced work to strengthen its use of linked population-level data through collaboration with the Secure Anonymised Information Linkage (SAIL) Databank. This work is exploring how routinely collected health and care datasets can be used to better understand population need, inequalities, service utilisation and outcomes across different population groups. Whilst still at an early stage, the work represents an important step towards developing a more sophisticated evidence base that combines traditional planning intelligence, population health analytics and service data to inform future commissioning intentions, service planning and prioritisation decisions. This approach has the potential to support a more systematic assessment of population need and move the organisation towards a more mature population health planning capability.	1. Make demonstrable progress towards a standardised population health assessment for the 28/29 planning cycle to allow greater triangulation of population need, inequalities, service activity, outcomes and partner intelligence. Use the findings to inform and evidence the prioritisation of commissioning intentions and corresponding plans.	Q1 27/28	Emma Ince /Cath Doman for RPB/ PH lead	1. 28/29 baseline assessment document will have visibly matured since the version in 27/28 and is actively used to conduct a population health assessment.	The 28/29 baseline assessment demonstrates a more systematic analysis of population need and inequalities, and there is clear evidence that its findings have influenced the selection and prioritisation of commissioning intentions and Clinical Board plans.
7. Priorities and Achievability	1	1	A7.1 CAVUHB Planning Process 27-28 A7.2 Clinical Services Plan (CSP) A7.3a 2027-8 Commissioning intentions with supporting and enabling actions A7.3b 2027-8 Commissioning intentions with primary and secondary targets A7.4 Prioritisation Methodology Template	A consistent prioritisation methodology for the UHB is not yet embedded, it recognises that planning remains reactive, however the CSP clearly sets out priorities for the organisation in order to deliver the future model of care which has informed the 27/28 commissioning intentions as part of the annual planning process. Progress has been made over the last 12 months and the UHB continues to move towards being L2; 27/28 is seeing the UHB adopt a commissioner / provider split in its approach to planning. Over time this will support the development of a prioritisation methodology. The baseline assessment referenced above is a key part of this.	1. Develop and test a prioritisation framework that reflects the Cardiff and Vale population needs assessment. Test and refine the framework within the planning / commissioning cycle.	Q2 27/28	Emma Ince / Jonathan Watts	1. An agreed prioritisation methodology that supports with future annual plan / IMTP development.	An agreed prioritisation methodology is consistently applied to commissioning intentions and plan proposals, with decisions demonstrably informed by population need, inequalities, strategic alignment, anticipated outcomes, affordability and deliverability. The resulting priorities and rationale are formally documented and approved.
8. Horizon Scanning	2	2	A8.1 Tertiary Services Development Group - Approved Terms of Reference A8.2 Tertiary Services Development Group - Updated Terms of Reference (awaiting approval) A8.3 Annual Plan Baseline Assessment A8.4 Horizon Scanning Report	Progress has been made over the last 12 months and the UHB continues to move towards being L3; A horizon scanning process was undertaken to inform the development of the CSP and was subseqently updated and used as a part of the baseline assessment to inform the 27/28 annual plan to inform priorities. The Tertiary & Specialised Services Planning Group regularly includes horizon scanning for specialised services, including Advanced and Complex Therapies given the rapid nature of emerging treatments and technologies in this areas. The UHB is also engaged in the ATW/Complex Pathway Mapping work and uses the AWTTC Horizon scanning to inform its provider planning.	1. Further mature the baseline assessment exercise which is undertaken as part of developing the annual plan to ensure it articulates long-term trends / opportunities / risks that are identified through 'horizon scanning'. 2. Horizon scanning assessment against developing enabling strategic plans including people and culture and estates plans (2025 priority action rolled over).	Q2 27/28 Q4	Victoria Le Grys Victoria Le Grys	1. Baseline assessment taken to Board 2. People & Culture Committee and Digital & Infrastructure Committee papers demonstrating how identified developments, risks and opportunities influenced planning decisions.	Horizon scanning is undertaken and reviewed by Board at least bi-annually, with identified developments, risks and opportunities documented and demonstrably used to inform strategic priorities, commissioning intentions, service plans and mitigating actions

B. Strategy Alignment and Development of an IMTP

2026 level: 1
2027 level: 1

Subcategory	2025 Subcategory Level	2026 Subcategory Level	Evidence used to support 2026 level	Supporting Narrative	Action (s)	Deadline	Lead	Evidence to be used	Impact Measurement
1. IMTP development	1	1	B1.1 26-27 Annual Plan B1.2 26-27 Planning Framework, Annual Plan Mapping Exercise	The UHB remains at L1 with the rate limiting factor preventing progression from this level being the ability to present a financially balanced plan over three years. As per last year the UHB continues to contend that this assessment criteria should be reviewed and adjusted as this single point makes it far too big a jump to move from L1 to L2 when lots of other positive things are happening across plan development. There are aspects of L2 which the UHB is actively addressing / improving upon. This includes "taking a structured approach to strategic priorities that is informed by baseline data" and "consideration of risk, outcomes and resource requirements".	1. Continue to develop a route and trajectory to financial sustainability (this will form a key action in the 27/28 annual plan). 2. Ensure a more mature approach to developing internal plans that address the UHBs priorities / commissioning intentions.	Q1 Q1	Andrew Gough Jonathan Watts	1. Financial plan 2. Outputs of Clinical Board and strategic programme internal planning for 27-28	Approvable annual plan improving financial position
2. Alignment between Clinical Services Strategy and Plan and the IMTP or Annual Plan	1	1	B2.1 Board Approved Clinical Services Plan (CSP) B2.2 27-28 Strategic Priorities B2.3a 2027-8 Commissioning intentions with supporting and enabling actions B2.3b 2027-8 Commissioning intentions with primary and secondary targets	The timing of this assessment means at the time of writing the UHB is still at L1 however it is our intention that by submission date of the 27/28 annual plan (March 2027) we would consider ourselves at L2. The internal planning process currently being gone through will ensure *"alignment is clear and coherent between the IMTP and CSS"* .	1. Develop appropriate delivery and planning mechanisms ensuring alignment between the CSS and annual plan delivery 26/27 and beyond (2025 priority action rolled over).	Q1	Victoria Le Grys	1. 27-28 annual plan; 27-28 plan delivery mechanisms	100% of 2027–28 Annual Plan priorities are demonstrably aligned to CSP outcomes, with named owners, milestones and measures; delivery is reviewed quarterly, and misalignment or underperformance results in documented corrective action.
3. Triangulation of Services	1	2	B3.1 Clinical Board Minimum Data Set	By the end of 26/27 planning year a minimum data set at directorate level will have been produced which aggregates up to clinical board level. This will include an improved aggregation of activity, workforce and finance with the caveat that only a small subset of activity is being used. There is still work to be done to make sure finance and workforce systems are fully aligned. Finance reporting is now done at directorate level, and workforce reporting will be moving in the same direction over the coming years.	1. Improve the Minimum Data Sets so that the workforce and finance data are increasingly aligned with activity. 2. Develop our operational performance and intelligence function to improve demand and capacity modelling.	Q4 Q4	Adam Wright Adam Wright	1. Minimum Data Set 2. Approved Plans and Business Cases	An integrated and aligned activity workforce and finance plan, supporting delivery of a sustainable operational position.
4. Commissioning	1	1	B4.1a 2027-8 Commissioning intentions with supporting and enabling actions B4.1b 2027-8 Commissioning intentions with primary and secondary targets B4.2 Strategic Commissioning Framework for CAV UHB	Progress is being made towards level 2, with commissioning intentions in place for 2027/8 that align to agreed organisational priorities, reflect some specific service priorities, and are informed by a baseline assessment that considers population health data, stakeholder input and performance data. The agreement of commissioning intentions, and the testing of plans against these intentions are processes that have been integrated into the 2027/8 annual planning process. The organisation does not yet have an agreed and approved operational commissioning process, there are plans to define and strengthen the strategic planning and commissioning function as part of a wider organisational redesign programme.	1. Seek to develop a strategic approach for the UHB to discipline commissioning and planning (2025 priority action rolled over) 2. Improve internal and external governance for commissioned services, improving decision making, accountability, transparency, the management of risk and the understanding of performance for commissioned services. 3. Seek to develop a robust evidence base to inform future commissioning intentions. 4. Develop and implement a Performance Management Framework.	Q4 Q3 Q4 Q1	Emma Ince Emma Ince Emma Ince Emma Ince	1. Organisational commissioning strategy and/or Commissioning and Planning Framework 2. Agreed commissioning governance process and associated reporting 3. 2027/8 Baseline Assessment 4. Agreed Performance Management Framework and associated reporting	An approved commissioning strategy and/or commissioning and planning framework is in place, and evidenced for 100% of newly commissioned services. Commissioning governance has been agreed and regular reporting is evidenced. The 2027/8 baseline assessment includes an improved and expanded evidence base that reflects: service need; population health data; and performance metrics. A Performance Management Framework has been approved, is operational and embedded across the Health Board, with reporting evidenced.

C. Dynamic and Engaged Planning

2025 Level: 2
2026 Level: 3

Subcategory	2025 Subcategory Level	2026 sub category level	Evidence used	Supporting Narrative	Action (s)	Deadline	Lead	Evidence to be used	Impact Measurement
1. Stakeholder Engagement	2	3	C1.1 CSP Public Engagement Report - March 2026 C1.2 CSP Colleague & Partner Engagement Report - March 2026	A comprehensive engagement programme was undertaken to support development of the CSP, including 20 weeks of public engagement and 12 weeks of staff engagement. More than 3,500 public voices contributed to the development of the plan, with targeted engagement activity undertaken to ensure participation from under-represented and seldom-heard communities. Feedback from engagement activities was used to inform the identification of priorities and shape the content of the CSP, ensuring that the plan reflected the needs and perspectives of the population, staff and stakeholders.	1. Deliver the 18-month stakeholder engagement programme and publish an engagement report in December 2027 demonstrating how feedback from staff, partners, communities and under-represented groups has informed, challenged and refined CSP implementation, impact assessments and planning decisions.	Q4	Sarah Tipping	1. Engagement Report December 2027 (18 months)	Engagement reaches a representative cross-section of communities and staff, with under-represented groups demonstrably included. The December 2027 Engagement Report evidences how feedback influenced decisions and plan delivery, reports participant satisfaction, and confirms that key themes and resulting actions were communicated back to stakeholders.
2. Service Delivery Risk and Issue Management Approach	2	3	C2.1 Organisational Risk Management Group Terms of Reference - launched July 2026 C2.2 Guidance on AMAT Risk Model C2.3 UHB Revised Risk Management Policy - approved February 2026 C2.4 Risk Management - Board Cover Report September 2026 C2.5 Tertiary Services Development Group - Approved Terms of Reference (now updated) C2.6 Tertiary Services Development Group - Updated Terms of Reference (awaiting approval)	During 2026, significant progress has been made in strengthening organisational risk management arrangements, including the establishment of the Organisational Risk Management Group and Board Committees. Revised risk management policies, guidance and processes have been implemented to improve consistency of risk identification, assessment and escalation across the organisation. The Corporate Risk Register was also approved by Board in September 2026. The increased use of AMaT risk management data has enabled greater identification of scrutiny of long-standing risks, high residual risks and areas where limited movement in risk profile may require additional challenge, action or escalation. The Tertiary and Specialised Services Planning Group has aligned specialised service risks with the clinical board risk registers to support a consistent approach to risk assessment and the identification of fragile specialised services. This consolidated view of risk informs the TSPG work programme, the partnership plan with SBUHB, and the development of the CAVUHB and NWJCC Annual Plan and IMTP.	1. Agreement of process for service planning and baseline assessment for active use in planning process including where formalised partnerships are in place	Q4	Katie Innes / Joanne Hill / Harriet Ryland	1. AMAT risk reports / Board & Committee Risk papers / Risk audit report findings; Portfolio Board papers and minutes, relevant partnership board minutes and papers	The impact of risk management improvements during 2026/27 will be measured through: Improved quality and consistency of risk assessments through risk moderation. Reduction in the number of long-standing risks with limited progress or unchanged risk scores. Enhanced Board and Committee assurance through stronger risk reporting and oversight. Improved compliance with the Risk Management Policy, evidenced through audits and risk register reviews. Greater use of AMaT data to identify trends, target support and challenge areas requiring further mitigation. Positive internal and external assurance regarding the maturity and effectiveness of risk management arrangements.
3. Service Model/ Regional Design	2	3	C3.01 Approved Terms of Reference for the Regional Joint Committee (RJC) C3.02 Regional Joint Committee Public Meetings and Papers C3.03 Approved Terms of Reference for the Cardiff & Vale Regional Planning Group C3.04 Clinical Services Plan (CSP) C3.05 Impact of Regional Ophthalmology Delivery C3.06 Business Cases for Regional Diagnostic and Regional Surgical Hub approved by Welsh Government/ Integrated Regional Plan to deliver regional service in Lower Limb Arthroplasty C3.07 Tertiary Services Development Group - Approved Terms of Reference C3.08 Tertiary Services Development Group - Updated Terms of Reference (awaiting approval) C3.09 CAV Velindre Executive Partnership Group Terms of Reference C3.10 Regional Executive Management Group - Methodology for Prioritising Regional Clinical Services C3.11 CAV RPB Terms Of Reference C3.12 CAV RPB 5-Year Joint Area Plan 2023-28 C3.13 CAV RPB Annual Delivery Plan 26-27 C3.14 Community by Design Terms of Reference C3.16 Integrated Neighbourhood Teams Project	*Regional Partnership Board* CVRPB has determined the regional partnership priorities for Cardiff and Vale, driving a coordinated approach to service development and delivery across the Health Board, LAs and Third Sector. The 5 year Joint Area Plan sets out those priorities with detailed plans articulated in the annual delivery plan. A key priority is the develpment of an Integrated Community Care System (ICCS) initally focusing on the development of proactive, coordinated care at home with a focus on prevention and early intervention.This is critical to ensuring better experience and outcomes and to mitigate demand on the NHS and social care system. Alignment of CbD to the ICCS enables the development of a more comprehensive integrated delivery model incorporating LA, Third Sector services alongside those of the Health Board and primary care. The RPB ensures that emerging care models are designed and implemented with the contribution of all relevant partners. *The RPB also oversees similar approaches for LD, dementia, neurodiversity and autism services, children and young people's services, digital, data and capital.* *Community By Design* The Community by Design programme was established in Summer 2026 as the Health Board's vehicle for community service transformation, contributing to the RPB's ambition to develop an ICCS. Three interconnected transformation workstreams have been established, focusing on Integrated Neighbourhood Teams, Urgent & Same Day Primary and Community Care, and developing an Integrated Care Model. Supporting enabling workstreams are in place to provide the intelligence, workforce, financial, planning and engagement foundations required to redesign services and shift care closer to home. Governance and oversight arrangements are in place to support service redesign and implementation. The programme is fostering stronger partnership working across health, local authority, primary care and third-sector organisations to design and deliver integrated neighbourhood-based services.	1. Agree and approve regional service models for priority services. 2. Implement agreed regional solutions and shared service arrangements. 3. Strengthen joint performance management and benefits realisation. 4. Embed collaborative workforce, financial and service planning. 5. Further develop and implement sustainable models for tertiary and specialised services through partnership arrangements with Velindre, SBUHB and other providers. 6. Monitor and evaluate the impact of regional service changes through the RJC and CAV Regional Partnership Board. 7. Further strengthen joint service model planning with Cardiff Council and Vale of Glamorgan Council to deliver component parts of the Integrarted Community Care System (Integratd Neighbourhood Teams, Single Point of Access, Discharge arrangements, intermediate care) and articulate with the RPB Annual Delivery Plan, HB plans and partner plans.	Q4 Q4 Q4 Q4 Q4 Q4 Q4	Victoria Le Grys (Katie, Jo and Harriet) /Cath Doman	RJC, Clinical Services portfolio Board and Regional Partnership Board minutes; approved regional service models and implementation plans; partnership agreements with Velindre, SBUHB and other providers; benefits-realisation and performance reports; workforce and service-resilience metrics; and patient access, outcomes and variation data demonstrating the impact of regional service changes; CAV RPB Annual Delivery Plan and quarter;y reporting; Community by Design programme documentation.	Increased delivery of services through regional and networked service models. Improved sustainability and resilience of priority, fragile and specialised services. Reduced variation in access, performance and outcomes across the region. Improved workforce resilience through collaborative planning and shared workforce approaches. Benefits realised through shared resources, workforce and service delivery. Effective oversight and accountability through the RJC and Cardiff & Vale Regional Partnership Board.

D. Operational Planning

2025 Level: 2
2026 Level: 2

Subcategory	2025 Subcategory Level	2026 sub category level	Evidence used	Supporting Narrative	Action (s)	Deadline	Lead	Evidence to be used	Impact Measurement
1. Demand and Capacity Modelling	1	2	D1.1 27/28 Demand and Capacity Programme Plan D1.2 Example of Demand and Capacity Template for RTT 2025-26	The planning process for the 2027/28 plan includes four operational demand and capacity model supplemented with an improved approach to the Minimum Data Set. 1. RTT - 104, 78 and 52 weeks at directorate level 2. 8-week diagnostics - MRI, CT, NOUS, Echo, Endoscopy 3. Cancer - 62-days 4. Bed Planning - admissions, discharges, LOS	1. Improve the integration of workforce and finance with the demand and capacity plans 2. Explore and if necessary begin developing our operational performance and intelligence function to improve demand and capacity modelling 3. Assess, and if viable, develop our whole system simulation model	Q4 Q4 Q3	Adam Wright Adam Wright Adam Wright	Demand and Capacity Outputs	An integrated and aligned activity workforce and finance plan, supporting delivery of a sustainable operational position.
2. Clinical Leadership and Input	2	2	D2.1 Community by Design Terms of Reference D2.2 SEW Regional Orthopaedics Programme Board Terms of Reference D2.3 Velindre Partnership Governance & Reporting Structure D2.4 CSP Oversite Group Terms of Reference D2.5 CSP Workshop Agenda 16.12.25 D2.6 CSP Workshop Agenda 16.01.26	The UHB remains at a L2, however progress is being made towards level 3. In some areas of planning there is evidence of good practice in ensuring clinical leadership is driving planning at the earliest stage. This is not yet embedded consistently across the UHB. Clinical leadership was also evident during the development of the CSP with clinical executive leadership and multiprofessional clinical leadership as part of the co-design.	1. Identified clinical lead for tertiary and specialised services planning 2. Revised strategic leadership team membership to ensure clinical board director ownership and oversight of planning processes and decisions 3. Establishment of health care professionals forum	Katie Q3 Q3	David Fluck Chris Bown David Fluck	1. ToR for tertiary and specialised services planning group 2. ToR for strategic leadership team 3. ToR for health care professionals forum	This action will strengthen clinical leadership and ownership within the CSP and fosters improved engagement, clinically-led service transformation and reinforces a culture of shared leadership.
3. Planning Process	1	1	D3.1 Clinical Board Executive Review Template D3.2 Clinical Board IMTP submission example D3.3 UEC Demand	This action is ongoing following recommendations from Tricordant and McKinsey.	1. Undertake a review of our operating model for planning in the organisation- including assessment of capacity and capability (2025 priority action rolled over)	Q3 27/28	Adam Roberts/ rachel Gidman	1. Board papers and organisational re-design papers	This impacts CAVUHB by strengthening its strategic delivery and internal governance. Clarifying roles and responsibilities across planning and operations will improve accountability and coordination, while assessing planning capacity and capability ensures the organisation is equipped to deliver on its priorities. Together, these actions will enhance planning effectiveness and support better use of resources.

E. Best Practice Approach to Improvement

2025 Level: 2
2026 Level: 3

Subcategory	2025 Subcategory Level	2026 Subcategory Level	Evidence used	Supporting Narrative	Action (s)	Deadline	Lead	Evidence to be used	Impact Measurement
1. Engagement	3	4	E1.1 CSP Public Engagement Report - March 2026 E1.2 CSP Colleague & Partner Engagement Report - March 2026 E1.3 SOFWBC Development Board Paper E1.4 Strategic Planning, Commissioning and Partnership Board Report - July 2026	Through development of our CSS/CSP, we engaged with over 3,500 individuals across our communities, with a specific focus on ensuring representation from diverse populations and seldom-heard groups. Feedback was systematically analysed and directly informed the development of the CSP, whilst also influencing wider programmes such as the Women's Health Plan and other strategic priorities across the organisation. This year we refreshed our approach to the stakeholder reference group which is now known as the "Shaping our Future Wellbeing Collaborative" (SOFWBC). The collaborative includes representatives from the communities we serve and has a range of professional and community voices. An 18-month programme of continued engagement supports ongoing dialogue beyond plan publication, and we are working collaboratively with neighbouring UHBs to support engagement on our regional work programmes. We have strengthened governance arrangements to increase the visibility of engagement at Board level, including the involvement of Independent Members within the collaborative and dedicated opportunities for Llais contributions within Board reporting structures. These arrangements help ensure engagement findings are considered routinely within decision-making processes and support continuous improvement across the organisation.	1. Refresh of the current Engagement Framework 2. Continue the development of the SOFWBC	Q4 Q4	Sarah Tipping Sarah Tipping	Board-approved refreshed Engagement Framework; SOFWB Collaborative terms of reference, membership records, agendas and annual report; public, staff and partner engagement reports; equality and representation analysis; and decision logs or service plans demonstrating how engagement feedback influenced priorities, service design and improvement actions	The refreshed Engagement Framework is approved and consistently applied, with the SOFW Collaborative demonstrating representative participation. Engagement reports evidence how public, staff and partner feedback has directly influenced service planning, improvement decisions and resulting actions.
2. Benchmarking	1	2	E2.1 GIRFT Report E2.2 UHW KPI Overview - Up to Aug 2026 E2.3 UHW Length of Stay Overview - Up to Aug 2026 E2.4 Benchmarking Example - National Hip Fracture Database Sept 2026 E2.5 Benchmarking Evidence Images - as confirmed the UHB draws upon multiple benchmarking sources, including NHS Wales datasets, Welsh Government frameworks, national clinical audits, Value Based Healthcare data, Royal College standards, GIRFT methodologies, HFMA reviews, Bevan databases and external consultancy reviews. This evidence document contains a number of screen shots of the benchmarking we do.	Cardiff and Vale University Health Board (CAVUHB) operates a comprehensive benchmarking programme to assess performance, productivity, quality, workforce effectiveness and financial efficiency. Benchmarking is undertaken at organisational, divisional and specialty levels and uses national, regional and external comparator data to identify variation, support service improvement, inform strategic decision-making and ensure value for money. The Health Board undertakes benchmarking across a wide range of areas, internally and externally, including: Financial benchmarking of expenditure, cost profiles, resource utilisation and efficiency against NHS Wales. As well as activity costs this would include CHC trends, prescribing, cost by functions and Health Resource Group (HRG), etc Workforce benchmarking covering staffing levels, skill mix, vacancies, sickness, agency usage and workforce productivity. Operational and productivity benchmarking, including theatre utilisation, outpatient productivity, bed occupancy, length of stay, diagnostic services, and patient flow. Clinical benchmarking through national audits, outcome measures, patient safety indicators and quality standards. Value-Based Healthcare benchmarking assessing outcomes achieved relative to resources consumed, including PROMs and PREMs as well as Value based procurements. Service and specialty reviews comparing service models, staffing, activity levels, productivity and outcomes with Welsh, UK and international comparators. Population health and demand benchmarking to understand demographic trends, disease prevalence and future healthcare requirements. External benchmarking and independent reviews undertaken with consultants and specialist advisors to validate performance assessments and identify improvement opportunities. These have included speciality focused NHS Benchmarking Network exercises – Covering specific services, comparison with UK organisations in terms of activity, access, service design, workforce, finance, quality and infrastructure	1. Develop our operational performance and intelligence function to improve approach to benchmarking. 2. 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 (2025 priority action rolled over)	Q4 Q4	Adam Wright Adam Wright	1. Development of team and production of benchmarking 2. Value 26/27 Plan; Value Impact Tracker	Delivery of best practice and more efficient and productive services.
3. Governance	2	2	E3.1 Annual Plan Development Group Terms of Reference E3.2 IIP Health Board Actions 26/27 - Draft E3.3 Integrated Performance Reporting Presentation - June 2026	The UHB has progressed positively and is now in the upper quartile of L2 as at Nov '26 but not yet firmly in a position to assess itself as L3 (although is projected to be by next year's assessment). Progress is reflected through a now fully functioning annual plan delivery group (APDG) which has senior representatives from across WF, Quality, Finance and operations with effective links into wider enabling functions such as estate and digital via an emerging corporate 'deputies group'. In addition there has been good early discussions with Board on revised integrated performance reporting / improved governance in this area.	1. Complete the following rolled over action from 2025 assessment which will complete with the submission of the 27-28 plan; Review planning process to fit with the objective of producing an 'acceptable' annual plan through (a) Clear planning assumptions and parameters appropriate to an annual plan (b) - Delivery focused: ensuring clear actions, milestones, measures and ownership 2. Ensure a fully developed Integrated improvement plan as part of the 27/28 plan 3. Agreement of a UHB PMF following further engagement with Board.	Q1 Q1 27/28 Q4	Jonathan Watts Victoria Le Grys/Emma Ince Emma Ince	1. Board approved priorities, planning requirements and commissioning intentions 2. Annual plan and supporting Clinical Board plans; IIP for 27/28 3. Board approved scope for a PMF	100% of 2027/28 plan actions have named owners, milestones and outcome measures; progress is reviewed quarterly structures set out in the PMF with quarterly reports to F&P committee. Fewer overdue or off-track actions

F. Realistic and Deliverable

2025 Level: 2
2026 Level: 2

Subcategory	2025 Subcategory Level	2026 Subcategory Level	Evidence used	Supporting Narrative	Action (s)	Deadline	Lead	Evidence to be used	Impact Measurement
1. Risk identification and management	2	2	F1.1 27-28 Clinical Board Commissioning Response Template F1.2 26-27 Annual Plan Actions Tracker	The UHB has made good progress over the last 12 months in terms of strengthening its risk identification and risk management as part of annual plan development and delivery - this is as a result of the action agreed last year and which has been rolled over to this year (the action will not be fully complete until the conclusion of the 27/28 planning cycle). Revised internal planning templates for 27/28 require a clearer identification of risk and issues earlier alongside identifying mitigating action earlier. The ongoing development of an integrated improvement plan (IIP) and the linked development of a UHB performance management framework (by March 2027) will strengthen the UHBs subsequent management of risk. This should position the organisation well for moving to L3 in the 2027 assessment.	1. Further mature the approach to deliver the annual plan/ IMTP by embedding a dynamic reporting process into existing organisational governance arrangements (2025 priority action rolled over)	Q1	Adam Roberts/ Vicky Legrys	1. Board approved 27/28 IIP; Board approved Performance Management Framework	IIP actively being reviewed, in an appropriate senior leaders forum (below Board) on at least a monthly basis with evidence of risk discussion and corrective action being agreed where appropriate.
2. Development of IMTP and track record	1	1	F2.1 26-27 Annual Plan	We recognise and take seriously the fact that for both 25/26 and 26/27 the UHB has not been able to produce a deliverable annual plan - this clearly places the UHB at L1. Through the UHBs 27/28 internal planning process, turnaround and wider improvement activities the organisation in seeking to position itself so that is in a position to 'consistently' develop robust annual plans and as a result move to L2.	1. Development of a credible 27/28 annual plan	Q1	Adam Roberts/ Vicky Legrys	1. 27/28 annual plan	Ministerial approval of plan
3. Monitoring and delivery	2	2	F3.1 Q1 Annual Plan Report 26-27 F3.2 Q2 Annual Plan Report 26-27	The UHB has further strengthened its approach to in year monitoring of plan delivery - this responds to feedback received by Board. The UHB recognises there is more to do to ensure "monitoring of the IMTP is consistently seen as BAU and integrated with performance" and thus be in a position to move to L3	1. Development of an integrated improvement plan (IIP) as a mechanism for effective plan delivery 2. Development of a Board approved performance management framework as a mechanism for ensuring the IIP is effectively embedded within the organisation as part of BAU	Q1 Q1	Adam Roberts/ Vicky Legrys Catherine Phillips/ Emma Ince	1. Board approved IIP 2. Board approved PMF	IIP actively being reviewed, in an appropriate senior leaders forum (below Board) on at least a monthly basis with evidence of risk discussion and corrective action being agreed where appropriate.

Report Title: *(needs to match agenda)*	Adult ICU Programme Business Case		Agenda Item No:		3.2
Meeting:	Finance & Performance Committee	Public	√	Meeting Date:	18th November 2026
		Private			
Lead Executive Title:	Executive Director of Finance				
Report Author/s Title:	Director of Capital, Estates and Facilities				

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

- The infrastructure of the existing unit is in a poor state of repair with the bed head services obsolete and the supplier no longer able to provide a spare for the electrical or medical gas services
- There is inadequate ventilation in the unit which now requires appropriate air conditioning
- The bed spaces are well below current standards expected and whilst the revised layout will not fully comply with the lates guidance they will be significantly improved and reduce the risk of infection spread.
- The inclusion of both fully compliant isolation rooms and segregation rooms provides improved IP&C provision.
- The investment provides a medium term solution to allow the HB to continue to provide the service necessary until a new facility is provided which has been discussed with WG

ADVISE *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

ASSURE *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

Board/Committee Response Required *(please select only one)*

To confirm the action Members are being asked to take considering the AAA Framework

Assurance		**Approval**	√	**Information/Noting**	

Recommendations

Recommendations should be clear, actionable, and aligned to the AAA summary above.

1) **NOTE:** the contents of the attached Executive Summary of the Programme Business Case
2) **RECOMMEND that the Board APPROVE:** the Programme Business Case for the phased refurbishment of the Critical Care Unit at the University Hospital of Wales, allowing submission to Welsh Government for scrutiny and to seek capital funding approval of £50.4m

Governance Route *(please list all other Committee/Groups this report has been to)*

***Where** it's been:*	***Capital Management Group***
***When** it went:*	*17th August 2026*
***What** decision was made:*	*The CMG endorsed the capital element of the business case (v5) to proceed through the internal governance process*

***Where** it's been:*	***Values & Benefits Realisation Group***
***When** it went:*	*2nd October 2026*
***What** decision was made:*	*The VBRG resolved to proceed with revenue affordability aligned with 'Option 1 - Maintain Current Service Configuration' i.e. no associated revenue implications, recognising that this option does not meet the longer term demand forecast for critical care beds but improves the infrastructure and capacity for decant.*
***Where** it's been:*	***Strategic Leadership Team***
***When** it went:*	*5th November 2026*
***What** decision was made:*	*SLT supported that the Programme Business Case be progressed through the internal governance process for submission to Welsh Government*

Main Report

Background & Current Situation

The purpose of the report is to request that the Finance and Performance Committee consider the attached Programme Business Case (PBC), for the phased refurbishment of the Critical Care Unit at the University Hospital of Wales, and support its progression through the UHB internal governance process for final approval by the Board at their meeting on the 26th November 2026. This will allow formal submission to Welsh Government (WG) to seek their support to progress the series of Business Justification Cases (BJC's) described within the PBC.

It has long been recognised that the existing Critical Care footprint at the University Hospital of Wales (UHW) does not comply with the required standards, in terms of bed spacing, infection and prevention control measures and infrastructure. Furthermore, the service is under significant pressure to meet the current demand within the available footprint which has risen considerably in the last 5 years and is predicted to continue to grow, impacting on the ability to manage surge capacity safely.

The primary purpose of this business case is to secure a fit-for-purpose Critical Care environment capable of safely supporting the high risk patients. The refurbishment is an essential investment in the infrastructure to sustain current service delivery and address significant estate, operational and resilience challenges.

The overarching PBC sets out the compelling case for change and the intention to improve the physical facilities across the third floor at UHW, on a phased approach. The first BJC, which is currently being developed for consideration by the Board at their meeting in March 2027, will include the associated works required in C3 North & South. The subsequent BJC's and phases of work will focus on A3 & B3, including an Isolation suite in A3 Link. The Business Case process described has been discussed and agreed with WG capital colleagues and NWSSP Specialist Estate Services.

The anticipated outturn cost of the scheme is £50.4m, inclusive of VAT. This also includes Optimism Bias at 34.56%. A breakdown of the cost is summarised in the table below

Capital Costs	Preferred Way Forward
	£000
Works Costs	20,476
Fees	3,774
Non-Works	951
Equipment Costs	2,244
Planning Contingency	2,744
Optimism Bias	10,433
Subtotal excluding VAT	**40,622**
VAT	6,007
Total Capital Cost at Approval	**46,629**
Inflation	3,773
Total Outturn Cost	**50,402**

The revenue implications and affordability options have been considered by the Values & Benefits Realisation Group (VBRG) with 'Option 1', Maintaining Current Service Provision, being the preferred outcome. This comprises of retaining 38 commissioned Level 3 equivalent beds within the existing operational footprint, with additional areas utilised solely for decant purposes during refurbishment works, responding to business continuity events etc.

Whilst this option avoids significant recurrent expenditure growth, it does not resolve the underlying operational and patient flow challenges and it should be noted that post refurbishment, maintaining 5 zones will mean operating out of a slightly smaller footprint (42 as opposed to 44 physical beds currently) as some bed spaces will be taken out as part of the refurbishment to create additional cubicle capacity. However, the projected increase in the number of available cubicles will alleviate the current pressures which arise when beds are closed due to IP&C.

Approval of the capital scheme does not commit the Health Board to an increase in commissioned capacity or immediate recurrent revenue expenditure. The preferred way forward maintains existing commissioned capacity whilst delivering the infrastructure required to improve operational resilience, patient flow and compliance with modern standards.

Due to the phased refurbishment programme and associated decant arrangements, the expanded footprint across Blocks A, B and C will not be fully operational until completion of the scheme, anticipated in 2030. Consequently, any revenue implications will not be realised until that time. This provides the Health Board with several planning cycles to identify and agree a sustainable funding solution through future IMTP processes, affordability reviews and commissioner discussions before additional recurrent costs are incurred. Any future proposal to increase commissioned capacity beyond existing levels would require separate business case approval, commissioner agreement and identification of recurrent funding.

Appendices:
(List any appendices that will accompany this report).

UHW ICU PBC v7 Executive Summary

Strategic Alignment – Shaping Our Future Wellbeing:
Please place an "X" against the strategic objective(s) this paper supports – Click the below tiles for further information.

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

Impact Assessment
Please ensure each section is completed. (If "Yes" is selected, complete the detail. If "No", please write "Not applicable".)

Risk: Yes

The current infrastructure does not meet the current standards and engineering infrastructure services are obsolete and not supported by manufacturers and suppliers. The lack of appropriate bed spacing and isolation/segregation rooms is a major IP&C issue.

Safety: Yes

The revised layout allows for increased bed spacing and isolation/segregation rooms which will improve IPC events

Financial: Yes

Capital funding support for the project is being sought via the All-Wales Capital Programme
The revenue affordability for the scheme has been considered and is described in the PBC

Workforce: No

Legal: No
Reputational: Yes
Failure of existing infrastructure could result in closure of beds and/or increased IP&C events
Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*
Equality & Health: No
Decarbonisation: Yes
Upgrade in mechanical and electrical infrastructure will improve efficiency
Welsh Language: No

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

Adult Critical Care Unit (CCU) at University Hospital Wales (UHW)

Programme Business Case: Executive Summary

October 2026 – Final v7

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

Contents

1.0 EXECUTIVE SUMMARY 5
1.1 Overview and Introduction 5
1.2 Strategic Case 6
1.3 Economic Case 18
1.4 Commercial Case 22
1.5 Financial Case 23
1.6 Management Case 27
1.7 Recommendation 30

Table of Tables

Executive Summary Table 1: Spending Objectives 11
Executive Summary Table 2: Summary Results from the Activity Modelling Project to 2030 15
Executive Summary Table 3: Revised Summary Results from the Activity Modelling Project to 2028 15
Executive Summary Table 4: Potential Scope 15
Executive Summary Table 5: Main Benefits 17
Executive Summary Table 6: Main Risks and their Counter Measures 18
Executive Summary Table 7: Development of Options / Long List Framework 19
Executive Summary Table 8: Summary of Economic Appraisal Outputs 20
Executive Summary Table 9: Economic Sensitivity Outputs 21
Executive Summary Table 10: Capital Costs for the Programme Preferred Way Forward 23
Executive Summary Table 11: Impairment for Programme Preferred Way Forward 23
Executive Summary Table 12: Future Operating Scenarios 25
Executive Summary Table 13: Bed Day Activity 2025/26 25
Executive Summary Table 14: Commissioner Revenue Activity 26
Executive Summary Table 15: Capital Impact on Income and Expenditure Account 27
Executive Summary Table 16: Project Roles and Responsibilities 28
Executive Summary Table 17: Initial Programme Plan 29

Table of Figures

Executive Summary Figure 1: Overarching National Policies considered within the PBC 8
Executive Summary Figure 2: Local policies considered within the PBC 9
Executive Summary Figure 3: Programme of Works Location Plan 21
Executive Summary Figure 4: Programme Reporting Structure 28

GLOSSARY / LIST OF ABREVIATIONS

A&E	Accident and Emergency
AHP	Allied Healthcare Professional
AME	Annually Managed Expenditure
BAU	Business as Usual
BCR	Benefits Cost Ratio
BECS	Built Environment Consultancy Services
BJC	Business Justification Case
BRP	Benefits Realisation Plan
CAR-T	Chimeric Antigen Receptor T-Cell Therapy
CC	Critical Care
CCU	Critical Care Unit
CIA	Comprehensive Investment Appraisal
CIS	Clinical Information Systems
CMG	Capital Management Group
CRB	Cash Releasing Benefits
CRI	Cardiff Royal Infirmary
CSF	Critical Success Factors
CVUHB	Cardiff and Vale University Health Board
DEL	Departmental Expenditure Limits
DTOC	Delayed Transfers of Care
EAC	Equivalent Annual Cost
ECMO	Extracorporeal Membrane Oxygenation
EHIA	Equality & Health Inequalities Impact Assessment
EPR	Emergency Preservation and Resuscitation
EU	European Union
FBC	Full Business Case
FICM	Faculty of Intensive Care Medicine
FM	Facilities Management
GP	General Practice/ Practitioner

GPICS	Guidelines for the Provision of Intensive Care Services
HAI	Hospital Acquired Infection
HBN	Health Building Note
HM	His Majesty's
HR	Human Resources
HTM	Health Technical Memoranda
IAAP	Integrated Assurance and Approval Plan
ICNARC	Intensive Care National Audit & Research Centre
ICU	Intensive Care Unit
IM&T	Information Management and Technology
IMTP	Integrated Medium Term Plan
IP&C	Infection Prevention and Control
IT	Information Technology
LTA	Long Term Agreement
LTV	Long-Term Ventilation
MECC	Making Every Contact Count
MTC	Major Trauma Centre
NHS	National Health Service
NPSV	Net Present Social Value
NWJCC	NHS Wales Joint Commissioning Committee
OBC	Outline Business Case
OJEU	Official Journal of the European Union
PACU	Post Anaesthesia Care Unit
PBA	Project Bank Account
PBC	Programme Business Case
PERs	Project Evaluation Reviews
PIR	Post Implementation Review
PPE	Post Project Evaluation
PPE	Personal Protective Equipment
PRINCE2	PRojects IN Controlled Environments

QB	Quantifiable Benefits
RPA	Risk Potential Assessment
SMART	Specific, Measurable, Achievable, Relevant, Time-bound
SO	Spending Objectives
SOC	Strategic Outline Case
SOFW	Shaping Our Future Wellbeing
SRO	Senior Responsible Owner
TUPE	Transfer of Undertakings (Protection of Employment)

UHB	University Health Board
UHL	University Hospital Llandough
UHW	University Hospital Wales
VAT	Value Added Tax
VFM	Value for Money
WG	Welsh Government
WHBN	Welsh Health Building Note
WHC	Welsh Health Circular
WICIS	Welsh Intensive Care Information System
WMC	Welsh Modelling Collaborative

1.0 EXECUTIVE SUMMARY

1.1 Overview and Introduction

The Programme Business Case (PBC) seeks to describe the overarching substantial need to carry out works within adult critical care at the University Hospital Wales (UHW). The works aim to resolve the environmental standards as far as is possible within the existing footprint including provision of additional single rooms and some limited expansion in capacity through refurbishing the existing department and completing some physical works to adjacent areas. The total value of the works covered by this PBC £50.4m (including optimism bias at 34.56%).

Revenue implications have been modelled based on 3 scenaries. However, given the likely timeframes for completion of the capital build, it is not expected that this will materialise as a commissioning consideration until the 2030/31 IMTP.

The specific elements of the programme of works will be advanced via three Business Justification Cases (BJCs):

- C3 North & South, including a single isolation suite within the A3 Link
- B3 North and South
- A Block North and South

It has long been recognised that the environment in which critical care services at the Health Board are delivered do not meet modern standards, especially in terms of infection prevention measures. Demand for critical care at the University Hospital Wales has grown rapidly in the last 5 years and is predicted to continue to grow, with a shortage of physical critical care beds predicted from the mid 2020's until delivery of a major rebuild as part of UHW2, for which there are no agreed timescales. The programme therefore should be considered as the first phase of requirements for emergency critical care within the UHW site. Even with the completion of works associated with this programme, significant risks (described later within this document) will remain in relation to existing critical care areas including non-compliance with Welsh Health Building Note (WHBN) 04-02 standards. These risks will impact on the quality of care provided to patients and the ability for critical care to manage unpredicted surges in demand.

The proposed facility outlined within this business case would unlikely be able to be linked to any new replacement for UHW due to the major rebuild of UHW for which there are no agreed timescales currently. However, much of the equipment would be suitable for transfer, dependent upon the timeframe for the delivery of any new facility.

Meeting Standards

Critical Care requires a high technical specification for facilities to promote efficient working, prevent cross infection and promote patient privacy and dignity at a life-threatening stage of life. The core of the UHW critical care unit (CCU - B3N and B3S) housed 15 critically ill adults and children when the building was built in 1971. Since that time, the number of bedside therapies available has increased greatly, and so have the standards. The UHW CCU is uncompliant in key parts of Health Building Note (HBN) 27 (1997) such as bed space sizes, all the way through to the current WHBN 04-02 (2016 standards).

The NHS Wales Health Collaborative Service Specification says the following: "Critical care facilities must be fit for purpose and comply with national standards for physical facilities or have a timeline for when national standards will be met (Guidelines for the Provision of Intensive Care Services (GPICS)-2 standard 1.3.1, Recommendation 1.3.1)".

GPICS-2 states the following standard: "Critical care facilities must comply with national standards. All new build units must comply with (W)HBN 04-02". GPICS-2 also states the following recommendations: "Existing units that do not comply should have a timeline to establish when national standards will be met. When planning or redeveloping a critical care area, Document HBN 04-02 should be considered with key stakeholders".

"Health Boards must have plans to ensure sufficient critical care capacity to meet the needs of their population. The Task and Finish Group on Critical Care made clear recommendations for additional critical care capacity to meet expected need and health boards are expected to demonstrate how they will deliver this in their Integrated Medium-Term Plans (IMTPs)."

The Welsh Government Task and Finish Group on Critical Care (2019) recommended an increase from a capacity of 26 level 3 equivalents to 50 level 3 equivalents capacity 'over the next few years. As of March 2025, only 38 level 3 equivalents have been delivered.

1.2 Strategic Case

Cardiff and Vale University Health Board was established in October 2009 and is one of the largest NHS organisations in the UK.

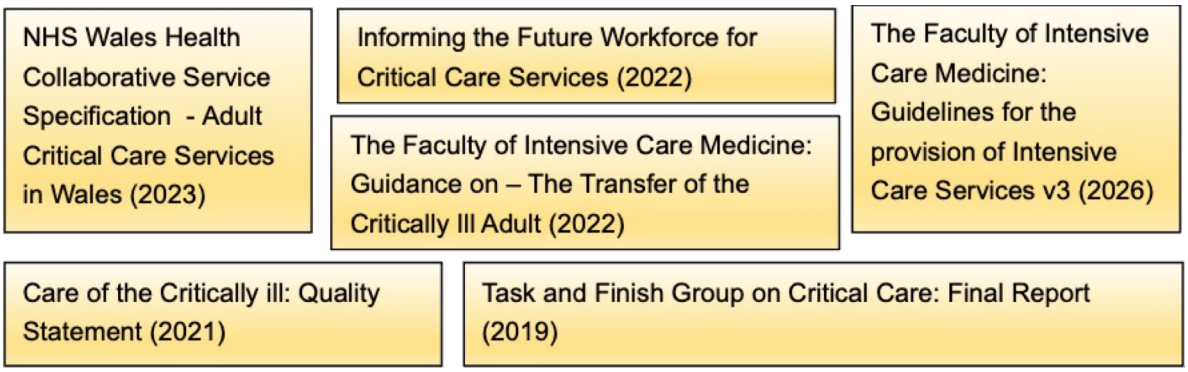
Since its establishment, the Health Board's priority has been to provide safe, high quality and sustainable services that compare well with the best in the world, with a focus on developing centres of excellence that support the actions needed to progress and deliver the vision 'to reduce health inequalities and deliver outstanding services for the population we serve'.

The Health Board has the following strategic objectives:

- Putting People First – The Health Board will be a great place to train, work and live, where the organisation will listen to and empower people to live healthy lives. By 2035, colleagues would recommend the Health Board a great place to work, workforce will reflect the diversity of communities, and more people will be living healthier lives

- Providing Outstanding Care – The Health Board 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. Inequities will be reduced in prevention, and there will be improved access to clinical services and clinical outcomes
- Delivering in the Right Places - By 2035 the Health Board 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. The organisation will be well on the journey to provide care in the right place, in facilities that are fit for purpose, flexible and promote recovery
- Acting for the Future – The Health Board will work to ensure that what is done today does not compromise the wellbeing of future generations. The Health Board 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 the Health Board's will have reduced its carbon footprint by 34% (currently under review) and will have increased research and clinical innovation activities.

The Health Board is confident that the strategic drivers for this investment and associated objectives, programmes and plans are consistent with national, regional and local strategy and policy documents. Some of the key NHS and Welsh Government policies that have shaped the critical care service programme are:





Executive Summary Figure 1: Overarching National Policies considered within the PBC

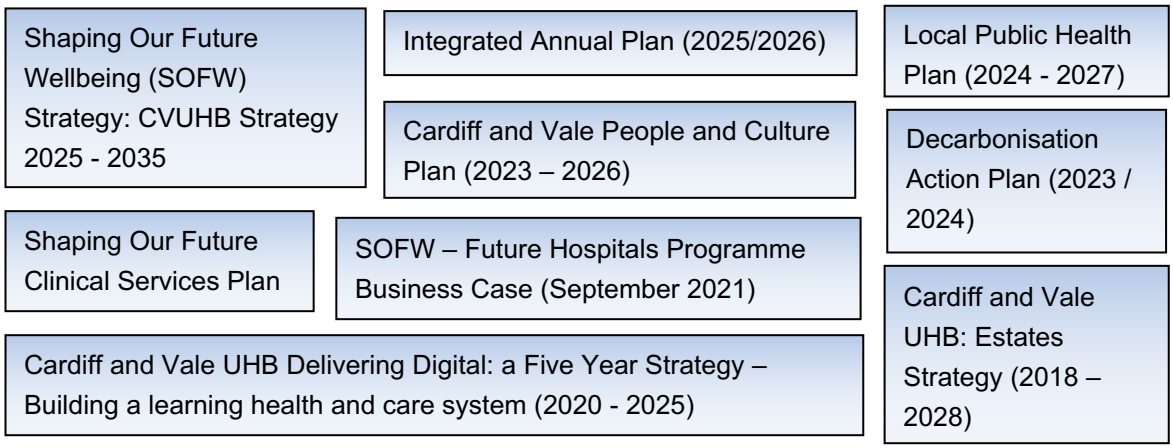
The PBC is supportive of the national strategies and guidance, which, given the challenges currently facing the CCU, clearly need to adopt new ways of working for the development of a safer, high quality, effective and resilient service that addresses the needs of the population, is responsive to current and future policy direction and ensures long term sustainability.

The programme business case presented will support the above overarching drivers and national policies by delivering the following:

- Ensuring the safety of patients and the quality of care through the provision of improved quality facilities that wherever possible meet quality and service standards including health building, technical and service standards
- Ensuring the Health Board provide the appropriate infrastructure to prevent hospital acquired infection and cross infection
- Essential maintenance and upgrading infrastructure to prevent unpredictable bed closures and loss of capacity

- Providing sufficient capacity to meet the clinical demand and ensure that all patients have equitable access to services across South Wales in the short term whilst accepting that the works will not provide a long term solution for critical care patients at UHW
- Providing improved quality facilities to enable the Health Board to attract and retain specialist staff
- Ensuring fit-for-purpose facilities that enable the introduction of best practice with efficient flows and adjacencies to enable the maximum use of facilities
- Backing the NHS workforce: by providing a pleasant working environment which permits the integration of services and collaboration which permits staff to deliver services to standards that are necessary
- Getting the most out of taxpayers' investment in the NHS: ensuring services are delivered efficiently through improvements in workflows

The PBC also takes cognisance of the relevant local Health Board strategies:



Executive Summary Figure 2: Local policies considered within the PBC

The programme will contribute to delivering these local strategies through:

- Emphasising a key area of the Integrated Annual Plan (2025/2026) which is to deliver exceptional specialist and tertiary services for local, regional, and national populations
- Where possible, addressing infrastructure compliance issues which is a key estate risk
- Assisting the Health Board to meet the themes set out in the Workforce Strategy for Health and Social Care in relation to the CVUHB People and Culture Plan by improving the experience of staff working within the service
- Providing settings that enable engaged, motivated and a healthy multi-professional workforce - to have a workforce that feels heard, valued and supported

There are many other local drivers in relation to multiple service developments that will impact on critical care services greatly in the future such as:

- Stroke Thrombectomy
- Chimeric Antigen Receptor T-Cell Therapy (CAR-T)
- Hepatobiliary Centralisation
- Severe Acute Pancreatitis Service
- Advanced Cancer Therapies

The proposals outlined within the programme business case would unlikely be able to be linked to any new replacement for UHW due to the major rebuild of UHW2 for which there are no agreed timescales currently. However, much of the equipment would be suitable for transfer, dependent upon the timeframe for the delivery of any new facility proposed.

The proposals within the programme are however linked to the following capital projects at UHW:

- Delivery of the Welsh Intensive Care Information System (WICIS) project. This is a vital but separate project which may run prior to the critical care programme, or concurrent with it
- Relocation of the existing Coronary Care Unit, Pacing Theatre and co-located Cardiology beds
- UHB winter site plans including capacity for and prioritisation of CC Delayed Transfers of Cares (DTOCs)

Spending Objectives

The specific spending objectives for the critical care programme business case include the following, along with how they will be measured:

Spending Objective 1: High Quality and Safe Service	
Specific	Ensuring the safety of patients and the quality of care through the provision of high quality services that fully meet required clinical standards and will support delivery of the highest possible standard of care, the rapid adoption of best practice, research and development and the regionalisation of services
Measurable	Evidenced by meeting the requirements of: ▪ Care of the Critically Ill Quality Statement (2021) ▪ Faculty of Intensive Care Medicine – Guidelines for the provision of intensive care services 2022 ▪ NHS Wales Collaborative Service Specification – Adult Critical Care Services in Wales 2023 ▪ National Patient Safety Plan for NHS Wales 2026 – 2031

Spending Objective 2: Provide a High Quality and Compliant Environment	
Specific	Increased compliance, within the constraints of the current building, with Welsh Health Building Note (WHBN) 04-02 and relevant infection prevention and control (IP&C) guidelines in areas with identified deficits and to enable the delivery of high-quality care and provide the clinical teams the appropriate environment in which to care for patients, including one which is conducive to the care of vulnerable people
Measurable	Evidenced by: ▪ Improved estate performance ▪ Compliance against environmental and service quality standards including air exchanges ▪ Increased number of single rooms both isolation and segregation ▪ Reduction in hospital acquired infections ▪ Optimises outcomes resulting from provision of enhanced environment
Spending Objective 3: Increase Capacity to Meet Expected Demand	
Specific	Maintain critical care capacity to meet demand in the short term
Measurable	Evidenced by: ▪ Occupancy rates ▪ Number of outliers (i.e. patients on the Post-Anaesthetic Care Unit and recovery that should be within critical care) ▪ Unmet need data or delays of >4 hours from acceptance to admissions
Spending Objective 4: Effective Use of Resources	
Specific	To maximise infrastructure to support the use of available resource and provide an environment that promotes improved service efficiencies and delivers a cost effective service with good use of available technology
Measurable	Evidenced by: ▪ Improved patient and staff experience ▪ Services provided within the identified revenue budget ▪ Reduced number of bed moves which occur primarily for IP&C issues
Spending Objective 5: Sustainability/Flexibility	
Specific	To provide a solution that will enhance the reputation of the Health Board and will support the delivery of safe and sustainable services in the short term and with built-in resilience to adapt to changing needs
Measurable	Evidenced by: ▪ Clinical and support room sizes to be as generic and flexible as possible to meet multiple uses wherever appropriate in the future ▪ Ventilation provision updated and replaced as required to meet current standards ▪ Capacity increased to meet short term demand

Executive Summary Table 1: Spending Objectives

The spending objectives relate directly to the five generic drivers for intervention and spend, they also align with the NHS Infrastructure Investment Guidance objectives and criteria.

Existing Arrangements

Unique in Wales

The Critical Care Directorate provides secondary, regional and tertiary level services for the population of Cardiff and the Vale and South Wales. Most critical care services in South Wales can be hosted interchangeably in any of the 12 CCUs in South Wales. Cardiff is unique in Wales in that the majority of its work is now tertiary, and most of Cardiff's services (e.g. Major Trauma and Neurosurgery) cannot be provided in any other CCU in Wales.

Growing Critical Care activity at UHW

Historically, critical care services were delivered across University Hospital of Wales and University Hospital Llandough (UHL) sites. Prior to 2020, UHL hosted a Long-Term Ventilation Service (LTV) which was co-located with one of the smallest critical care units in the UK. Critical Care services were permanently consolidated onto the UHW site during the COVID-19 pandemic. Additionally, UHW was commissioned to become a Major Trauma Centre (MTC) in 2020 between waves 1 and 2 of the COVID 19 pandemic. Furthermore, there have been two major increments of critical care commissioning to meet identified unmet general critical care need which have occurred in 2018 and 2023.

The above changes have resulted in significant expansion of critical care activity on the UHW site in the last 5 years. This has resulted in movement of existing or newly commissioned activity onto the UHW site equal to an additional 12 level 3 equivalents of emergency critical care activity, without concurrent emergency critical care infrastructure change. This is the equivalent to the addition of two new district general critical care units on the UHW site. This additional activity has only been possible by utilising spare physical beds in the existing footprint, an unplanned surge during the COVID 19 pandemic, and multiple relocations of the Post-Anaesthetic Care Unit (PACU). Five years later critical care services still routinely use these on a daily basis.

Professional modelling undertaken by the NHS Wales Delivery Unit in 2022-23 predicts the current trend for increasing critical care demand on the UHW site will continue to increase during the lifespan of the current hospital, and without action there will be major mismatches of demand and capacity especially between 2030 and 2035. More recent evaluations of current demand align with the predictions made in 2022-23 (completed March 2025), demonstrating year on year 4-5% growth in number of admissions. During the same period, there has been an overall reduction in critical care capacity across NHS Wales, placing further pressure on services within UHW.

Current Issues / Challenges

A report from the Royal College of Anaesthetists was commissioned by the Health Board in April 2019, to undertake an external review of its critical care services, to provide independent and expert advice with regard to the development of safe, sustainable services now and in the future. The invited review remit included the University Hospital Wales and

University Hospital Llandough. The recommendations contained in the report are intended to be used as a framework for managing and implementing change with the recommendations including:

- The review team strongly encourage for consideration and funding to be agreed for a new intensive care unit (ICU) at UHW. The board must recognise there is currently a lack of resource for ICU, this cannot be addressed by the extra beds commissioned in Feb 2019 alone (capacity, infrastructure and impact on patient quality care)
- A review of the overall infrastructure, particularly at UHW should take place. It is recognised that the footprint of the ICU at UHW is limited, but the executive board should review and work transparently with the ICU unit to improve the estate strategy. The plans presented to the review team during the visit were well detailed and should be considered but are still not likely to be adequate for need in relation to capacity, infrastructure and impact on patient quality care

More recently, in September 2025, a Coroner's inquest implemented a Prevention of Future Deaths regulation 28 and 29, highlighting infrastructure and capacity as a matter of concern. The South Wales Central Coroner stated:

"Due to the age of the hospital building, maintenance is a constant battle. There are also capacity issues in critical care due to patient volumes. Building infrastructure had been a constant feature on the corporate risk register and was now scored at its highest level. Whilst measures have been put in place to safeguard against moving patients who require critical care from the CCU, there remained fears that these systems would fail during times of pressure."

In addition to capacity issues, the infrastructure hosting the CCU is diverse, and does not meet modern standards. Some of critical care is hosted in the original 1971 ICU, and it should be noted that whilst the recommended bed space sizes have increased greatly since that time, in 2023 there are now 18 critical care beds in a space which cared for 15 patients in 1971. Additional areas are adapted PACU areas designed for patients staying up to 48 hours, which now care for patients with chronic critical illness with an expected critical care stays in excess of one to two months.

Many of infrastructure deficits identified are fundamental in preventing hospital acquired infection (HIA) and cross infection, which is vital as UHW hosts the sickest and most immunosuppressed critical care patients in Wales. Five years after the COVID 19 pandemic the service is still co-horting respiratory patients, whereas most UK critical care units care for them in single rooms. Co-horting also means not every bed in the footprint can be used at once, reducing the available capacity across critical care.

In the last five years the critical care unit has experienced periodic unplanned losses of capacity up to a maximum of 10 beds due to flooding, including infestation due to covert leakage of soiled water. Whilst recent works to the drainage systems have improved the situation, over the last 12 months, the critical care unit has also experienced four substantial electrical losses resulting in the need for rapid patient transfer and loss of emergency

admitting capacity for up to a week. This places unnecessary risk on patients being treated within the critical care unit, severe limitations on the ability to admit patients, and significant distress to the healthcare staff delivering care.

Business Need

As outlined above through the current issues experienced by the service, it has long been recognised that the environment in which critical care is delivered does not meet modern standards, especially in terms of infection prevention measures. Demand for critical care at UHW has grown rapidly in the last five years and is predicted to continue to grow, with a shortage of physical critical care beds predicted from the mid 2020's until delivery of a major rebuild as part of UHW2 the timescale for which is unknown at this time. Demand will outstrip capacity by the end of 2028, with the critical care unit always operating far above the suggested 70% occupancy target. It is essential therefore that the infrastructure of the unit remodels to ensure it meets patient demand, meets modern standards for prevention of cross infection and facilitates recruitment and retention.

Key aspects the programme aims to ensure for the service moving forward include:

- Safety - Reduce cross infection in a post COVID world by:
- Single Rooms. An increase in bed spaces provided in single bedrooms
- Hand Hygiene. Hand washing facilities should be improved, with sinks on all entrances and one per two bed spaces
- Reliability - Modernisation of gas and electrical supplies / pendants. Modernisation of air flow upgrading to 10 air exchanges per hour
- Efficiency - Any design should maximise nursing efficiency and patient visibility (and patient privacy when needed). The CCU should be able to host the All-Wales Clinical Information System
- Patient / Relative experience – Enhance patient and relatives experience through a reduction in noise levels, providing bathroom facilities for ambulant patients and provision of appropriate visitor's facilities

The 2019 Invited Review by Faculty of Intensive Care Medicine (FICM) recommended the following:

"It is recommended that a board agreed, critical care demand and capacity plan be developed and funding identified. This plan should describe the 5 and 10-year critical care capacity requirements".

Modelling work was undertaken by the clinical team in conjunction with professional modellers from the NHS Wales Delivery Unit and supported by the Health Foundation. The outcome of the work resulted in the following bed requirements for 2030:

	Current	Project Capacity (2030)
Emergency CC Beds	44	53
Elective CC Beds (PACU)	8	12
TOTAL	**52**	**65**

Executive Summary Table 2: Summary Results from the Activity Modelling Project to 2030

Following the development of the model, further work has been undertaken to assess the bed requirements in the shorter term (to 2028) – the following table provides a summary of the outputs of this work:

	Current	Project Capacity (2028)
Emergency CC Beds (inc LTV)	44	48
Elective CC Beds (PACU)	8	12
TOTAL	**52**	**60**

Executive Summary Table 3: Revised Summary Results from the Activity Modelling Project to 2028

The above figures both assume no growth in the LTV service.

Based upon the current arrangements and challenges, there is a clear need to expand the existing capacity for critical care, to at least meet 2028 requirements. Future expansions may be required depending on the lifespan of critical care within UHW.

Potential Scope

Welsh Government guidance assesses the scope against a continuum of need ranging from:

- A minimum – essential or core requirements/outcomes
- An intermediate – essential and desirable requirements/outcomes
- A maximum – essential, desirable and optional requirements/outcomes.

	Core	Desirable	Optional
Potential Scope	Provide a facility that partially meets requirements, in particular to resolve the ventilation issues	Provide a facility that partially meets requirements, in particular to resolve the ventilation issues and to provide additional single rooms	Provide a facility that fully meets all requirements
Key Service Requirements	Sized as current bed numbers with no increase in beds or side rooms	Sized to meet demand to 2028	Sized to meet demand to 2035

Executive Summary Table 4: Potential Scope

During the scoping of the programme of works, it is crucial that critical care should retain reliable physical links to Radiology, Theatres and the Emergency Department. It should also be noted that Extra-Corporeal Membrane Oxygenation (ECMO) is currently excluded from the scope of the programme, as this is not yet a commissioned service.

Main Benefits

This section describes the main outcomes and benefits associated with the implementation of the investment:

Spending Objective	Stakeholder Group	Main Benefits
Objective 1: High quality & safe service	Patients	▪ QB - Meet Emergency and Elective Critical Care capacity needs ▪ QB - Increase in the number of single rooms ▪ QB – decrease in patient bed moves for staffing and IP&C purposes ▪ QB - Increased ability to admit patients referred for JCC tertiary services e.g., Long Term Ventilation & Weaning in a timelier manner
	Health Board / Staff	▪ QB - Meeting demand for new and expanding tertiary services and moderate pandemic surges ▪ Non CRB - Ability to cohort respiratory patients appropriately
	Wider Health Community	▪ QB - Reduction in avoidable critical care bed closures due to infection prevention measures by improving compliance with IP&C standards for physical facilities
Objective 2: Provide a high quality/ compliant environment	Patients	▪ Non QB - Significantly reduce clinical risk relating to non-compliance with WHBN 04-02 ▪ Non QB - Enhance patient and relatives experience/ modernised environment ▪ Non QB - Reduction in noise ▪ Non QB - Increased patient visibility ▪ Non QB - Enhanced patient privacy where possible
	Health Board / Staff	▪ Non QB - Enhanced staff experience through an improved environment ▪ QB - Increase in number of handwashing facilities/ PPE stations resulting in reduction in cross infection ▪ QB – Improve electricity and gas supplies to reduce the risk of avoidable bed closures ▪ QB – Reduce inappropriate storage in corridors/public areas
	Wider Health Community	▪ Non QB - Improve patient and relative experience during admission to Critical Care

Spending Objective	Stakeholder Group	Main Benefits
Objective 3: Increase capacity to meet expected demand	Patients	▪ QB - Increase access to Critical Care, particularly for Emergency patients with predicted mortality in the 5-20% range who can access Critical Care more easily in other UK Critical Care Units, but not Wales. This benefit would extend to all South and Mid Wales as Cardiff is the main provider of tertiary Critical Care Services
	Health Board / Staff	▪ Non CRB - Ability to cohort respiratory patients appropriately ▪ Non QB - Reduced IP&C related patient moves within footprint
	Wider Health Community	▪ Non QB - Provide critical care provision as close to home as possible when required
Objective 4: Effective use of resources	Patients	▪ QB - Increased access to critical care within 4 hours of decision to admit
	Health Board / Staff	▪ QB - Resources to assist in the ability to host the Welsh Intensive Care Information System (WICIS) ▪ QB – Improvements in workforce efficiency through maximisation of available bedspaces
	Wider Health Community	▪ Non CRB - Provision of a Critical Care Unit which will allow the Critical Care Service to direct its attention outside its walls to collaborate with the wider hospital on projects to reduce whole hospital mortality
Objective 5: Sustainability/ flexibility	Patients	▪ Non QB - Support the commissioning and expansion of multiple new specialist services such as CAR-T therapy and Stroke Thrombectomy which are more developed elsewhere in the UK. These services have proven records of dramatically transforming patient outcomes
	Health Board / Staff	▪ Non CRB - Improve recruitment and retention of Critical Care staff by providing modern facilities comparable to most Critical Care Units in the UK, to ensure all commissioned beds are open ▪ Non QB - Reduce period loss of capacity due to failing infrastructure (plumbing, gases and electrics)
	Wider Health Community	▪ Non QB - Ensure critical care services continue to be provided at UHW in line with the needs of the population

Executive Summary Table 5: Main Benefits

Main Risks

The table below provides a summary of the key risks that might affect the delivery of the programme of works along with counter measures:

Risk Description	Counter Measure	Design Development	Implementation	Operational
Maintaining sufficient bed capacity during the delivery of the scheme	Operational plan to identify bed capacity availability		✓	
Disruption to adjacent areas – storage solution, site wide, diverted access within hospital	Ongoing review and management with escalation as appropriate		✓	
Scheme not completed on time, based on phased approach to meet bed pressures	Detailed logistical planning to minimise impact upon operational services		✓	
The availability of capital funding to support the development	Included as a priority scheme for WG potential end of year slippage monies		✓	
Unexpected inflation	Where unexpected cost increases occur escalation to WG		✓	
Maintaining WHBN/WHTM compliance within a smaller footprint	Any derogations will be considered and agreed with the clinical team	✓		
Lack of ability to surge above current footprint	Review internal escalation plans, with proposes escalation plan during each construction phase			✓
Impact of construction noise for adjacent patients	Monitor impact on patients and minimise description re hours/times of construction works		✓	
Availability of suitable decant space	To be discussed prior to construction	✓		
The potential impact of the Iran War on delivery i.e. Material and Costs	Review market forces throughout programme with early procurement to be undertaken where applicable		✓	

Executive Summary Table 6: Main Risks and their Counter Measures

1.3 Economic Case

Critical Success Factors and Options Development

The critical success factors (CSFs) for the programme business case were taken from the Welsh Government guidance and endorsed by the programme board and programme / project team as follows:

- CSF 1 – Strategic Fit and Business Needs
- CSF 2 - Optimisation of Cost and Benefits (VFM)
- CSF 3 – Supplier Capacity and Capability

- CSF 4 – Potential Affordability
- CSF 5 – Potential Achievability

These CSFs have been used alongside the spending objectives for the programme to evaluate a list of possible options. An infinite number of options and permutations are possible; however, within the broad scope outlined in the strategic case and utilising the Treasury Green Book and Infrastructure Investment Guidance options framework.

The long list option findings for the current critical care unit are summarised below:

Framework Options	Business as Usual (BAU)	Minimum	Intermediate	Maximum
Potential Service Scope Options – as outlined in the strategic case	Existing provision with no improvements	Limited refurbishment of existing areas, in particular to resolve the ventilation issues	Limited refurbishment of existing areas, in particular to resolve ventilation issues with some expansion into adjacent areas to provide a limited increase in capacity & provide a greater number of single rooms	Reprovision of the critical care services either through complete refurbishment of the existing department, and expansion into adjacent areas or a new build solution
	Discounted	Discounted	Preferred Way Forward	Discounted
Potential Service Solution Options – in relation to the preferred scope	Refurbishment of existing areas, in particular to resolve the ventilation issues with some limited expansion into adjacent areas to provide an increase in emergency and elective capacity and to provide a greater number of single rooms			
Potential Service Delivery Options - in relation to preferred scope and solution	3.1 In-house		3.2 Strategic Partnership	3.3 Outsource
	Preferred Way Forward		Discounted	Discounted
Potential Implementation Options – in relation to preferred scope, solution and method of service delivery		4.1 Phased		4.2 Big Bang (single phase)
		Preferred Way Forward		Discounted
Potential Funding Options – in relation to preferred scope, solution, method of service delivery and implementation		5.1 Public Funding		5.2 Private Funding
		Preferred Way Forward		Discounted

Executive Summary Table 7: Development of Options / Long List Framework

The drive of the programme and subsequent project business justification cases is to improve access to critical care services through increased capacity, increase the efficiency of the available capacity, resolve the environmental standards as far as is possible, and to provide additional single rooms.

Utilising the outcome of the options framework above, all the options that were discounted as impractical have been excluded at this stage. The only viable option therefore that can be considered is:

- Limited refurbishment of existing areas, in particular to resolve the ventilation issues
- Expansion into adjacent areas to provide a limited increase in capacity and providing a greater number of single rooms, and improved efficiency across the available capacity
- Size to meet demand to 2028 for both elective and emergency workstreams

Economic Appraisal

An economic appraisal has been carried out as part of the development of the PBC. A comprehensive investment appraisal (CIA) has compared the preferred way forward at this stage against the business as usual option as a baseline.

There are currently two options for delivering the programme of works and the final selection will be made following a full assessment of the available areas for decant. The two options include:

- Option 1 Ward by Ward
- Option 2 Block by Block

Option 2 is the current preferred way forward; however, the economic appraisal has been undertaken using option 1 as this is the worst case scenario.

All the key costs, risks and benefits have been run through the national CIA model and the result outlined in the table below. This shows that option 1 is strongly preferred with a benefit cost ratio (BCR) of 6.09.

The economic appraisal is summarised in the table below:

Economic Cost	Do Nothing	Option 1
	£000	£000
Incremental Costs		(10,510)
Incremental Benefits		64,001
Risk Adjusted NPSV		53,490
BCR		6.09

Executive Summary Table 8: Summary of Economic Appraisal Outputs

A summary for the sensitivity analysis which shows the movement on key elements of the economic analysis to switch the preferred option is shown below. In all cases the switch is significant and unlikely to occur at that level. The preferred way forward is therefore strongly preferred from an economic perspective:

Economic Cost	Value	%
	£000	£000
Capital Costs	63,994	609%
Revenue Movement	28,835	117%
Other benefits	15,475	41%

Executive Summary Table 9: Economic Sensitivity Outputs

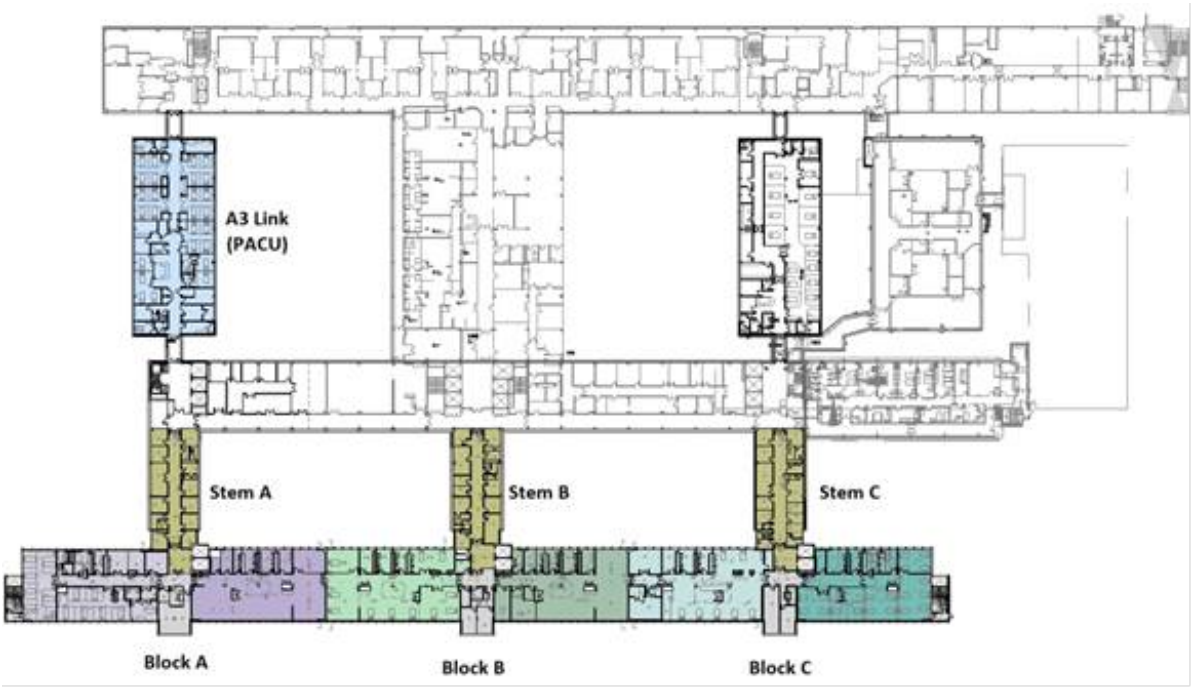
Preferred Way Forward

The specific phases required to deliver the programme will be advanced via three business justification cases. The BJCs will cover the following program of refurbishment works:

- C3 North & South, including a single isolation suite within the A3 Link
- B3 North and South
- A Block North and South

The works entail demolition work and a full refurbishment of the existing units and installation of new WHTM compliant air handling units within the plantroom and one on the lower roof.

The following diagram shows the location of the areas where works are to be undertaken:



Executive Summary Figure 3: Programme of Works Location Plan

As outlined the in economic case, there are currently two options for delivering the programme of works and the final selection will be made following a full assessment of the available areas for decant. The two options include:

- Option 1 Ward by Ward
- Option 2 Block by Block

Option 2 is the current preferred way forward, however the construction programme / key milestones to date have also included option 1 should full decant areas not be achieved.

The proposed construction period will cover approximately between 136 and 155 weeks depending upon the final choice of decant option. Programme option 1 is 155 weeks and programme option 2, 138 weeks. This includes construction through to commissioning although the start date for this is dependent on the business case approvals process.

1.4 Commercial Case

The required scope of works is to refurbish the existing critical care unit on level 3 at UHW.

The work involves a phased programme of refurbishment works to C3 North & South including an A3 Link isolation suite, B3 North and South, A Block North and South and installation of WHTM compliant air handling units.

The procurement options considered by the Health Board to date include:

- Traditional tender process
- Single tender action to an individual contractor
- Utilising the Scape Built Environment Consultancy Services ("BECS") Framework
- Utilising SEWSCAP4 Framework
- Using the Design for Life procurement framework

The Health Board will procure a Supply Chain Partner (SCP) through the SEWSCAP4 Framework. This Framework is the South East & Mid Wales Collaborative Construction Framework.

The quantity surveyor has been appointed via the Shared Business Services (SBS) Healthcare Planning, Construction Consultancy and Ancillary Services (HPCCAS) Framework Agreement. The appointed company is Gleeds Cost Management.

The Project Management role will be undertaken by a member of the Health Board's Estates and Facilities Team.

The procurement strategies are in line with the procedures and practices as laid down in the framework utilising NEC4 option A.

1.5 Financial Case

Capital Costs

The anticipated investment the PBC seeks approval of is £50.4m (including optimism bias at 34.56%). A breakdown of the capital costs is summarised below:

Capital Costs	Preferred Way Forward
	£000
Works Costs	20,476
Fees	3,774
Non-Works	951
Equipment Costs	2,244
Planning Contingency	2,744
Optimism Bias	10,433
Subtotal excluding VAT	**40,622**
VAT	6,007
Total Capital Cost at Approval	**46,629**
Inflation	3,773
Total Outturn Cost	**50,402**

Executive Summary Table 10: Capital Costs for the Programme Preferred Way Forward

Depreciation and Impairment

	2027/28 £000	2028/29 £000	2029/30 £000	2030/31 £000
AME Impairment	-7,011	-3,723	-2,388	0
AME Reversal of Impairment	0	0	0	0
Total Impairment	**-7,011**	**-3,723**	**-2,388**	**0**
Depreciation – Build	0	-103	-75	-81
Depreciation - Equipment	0	216	259	312
Total Depreciation	**0**	**113**	**184**	**231**

Executive Summary Table 11: Impairment for Programme Preferred Way Forward

Impairment will be calculated based on advice from the District Valuer. The asset value post impairment will be depreciated over the estimates useful economic life provided by the District Valuer.

The PBC assumes that the impairment charge will be funded by Welsh Government.

Revenue Costs

The primary purpose of this business case is to secure a fit-for-purpose Critical Care environment capable of safely supporting the existing commissioned service of 38 Level 3 equivalent beds. The refurbishment scheme should not be viewed as a commitment to increase commissioned capacity, but as an essential investment in infrastructure required to sustain current service delivery and address significant estate, operational and resilience challenges.

Three future operating scenarios have been modelled to inform financial planning, without committing the Health Board to future revenue costs which can be determined later:

Option 1: Maintain Current Service Configuration	Retain 38 commissioned level 3 equivalent beds within the existing operational footprint, with additional areas utilised solely for decant purposes during refurbishment works, responding to business continuity events etc. Whilst this option avoids significant recurrent expenditure growth, it does not resolve the underlying operational and patient flow challenges and it should be noted that post refurbishment, maintaining 5 zones will mean operating out of a slightly smaller footprint (42 as opposed to 44 physical beds currently) as some bed spaces will be taken out as part of the refurbishment to create additional cubicle capacity. However, the projected increase in the number of available cubicles will alleviate the current pressures which arise when beds are closed due to IP&C. This option does not meet the longer-term demand forecast for Critical Care beds, it does provide capacity for decant, allows for a considerably improved infrastructure, increases the number of cubicles and future-proofs the capacity in the short term to respond to any potential newly commissioned services.
Option 2: Maintain Current Commissioned Capacity Across an Expanded Refurbished Footprint	Maintain 38 commissioned Level 3 equivalent beds following completion of the refurbishment programme, operating across an improved, larger and more resilient footprint. Whilst this option does not seek an increase in the number of commissioned level 3 critical care beds and therefore avoids the significant additional workforce and revenue requirements associated with this, it does enable the existing commissioned service to be delivered more effectively within a modernised environment designed to address current estate constraints, improve operational resilience, support infection prevention and control requirements, and provide greater flexibility to manage patient flow and future demand pressures. The current physical footprint often constrains the volume of activity that can be delivered, resulting in patients outlying into Recovery/PACU on occasion. Whilst the commissioned capacity in this option remains unchanged, operating across a larger footprint could require additional investment if the same medical model is retained in the future. The Clinical Board will commence discussions on potential future options for the medical model with the Critical Care Directorate. In the meantime, and for the purposes of this scenario, costs have been calculated based on retaining the current model. There will also be some elements of non-pay expenditure (e.g. facility overheads) to ensure safe and effective delivery of care across the expanded clinical environment. The nursing establishment associated with delivery of the existing 38

	commissioned Level 3 equivalent beds remains aligned to current commissioning assumptions; however, an additional senior zone leader will be required to safely oversee the expanded operational footprint. Importantly, these additional costs are contingent upon completion of the refurbishment programme and occupation of the final operational configuration across Blocks A, B and C. As a result, it is anticipated that any revenue consequences will not be fully realised until the programme is complete, currently anticipated in 2030. It should be noted that this option and the associated financial assumptions are focused solely on the workforce and operational costs required to safely deliver the existing commissioned critical care capacity across the expanded footprint. Whilst significant progress has been made in strengthening the nursing workforce in recent years, investment in other professional groups, including Allied Health Professionals (AHPs) and pharmacy services, has not kept pace with service growth and increasing patient complexity. These wider workforce pressures are recognised but are outside the scope of this business case and will require consideration through future workforce planning and investment programmes to support progression towards GPICS-recommended multidisciplinary staffing levels.
Option 3: Increase Commissioned Capacity	A future increase in commissioned capacity beyond 38 Level 3 equivalent beds would require additional recurrent investment across all staff groups and non-pay budgets, together with agreement from multiple commissioning organisations. This would represent a separate future commissioning decision and is not required to support approval of the capital investment.

Executive Summary Table 12: Future Operating Scenarios

The Value & Benefits Realisation Group have supported progression of Option 1 as the preferred affordable option and requested further work to explore whether the benefits associated with operating across six zones could be achieved within existing staffing and resource levels.

The revenue consequences of the business case also need to be considered in the context of multiple commissioning arrangements.

Commissioner	Bed days	Utilisation
CVUHB	2,915	32%
Other UHBS	1,287	14%
NWJCC	4,736	52%
NHS England	210	2%
Total Activity	**9,148**	**100%**

Executive Summary Table 13: Bed Day Activity 2025/26

At the current commissioned capacity of 38 level 3 equivalent beds, the revenue uplift would be transacted through NWJCC and HB LTA activity contracts through an increased bed day rate equivalent to £239 per occupied bed day. The uplift would need to be included in the relevant year IMTP development process to align with the capital development.

For CVUHB commissioned activity a block revenue uplift of £0.697m would be required.

Commissioner	Option 2 £000
Cardiff & Vale	697
Other UHBs	305
NWJCC	1,133
NHS England	44
Net Increase Revenue	**2,178**

Executive Summary Table 14: Commissioner Revenue Activity

Executive Assurance

The purpose of this business case is to secure a safe, fit-for-purpose critical care environment to support the current commissioned service of 38 level 3 equivalent beds. Approval of the capital scheme does not commit the Health Board to an increase in commissioned capacity or immediate recurrent revenue expenditure. The preferred way forward maintains existing commissioned capacity whilst delivering the infrastructure required to improve operational resilience, patient flow and compliance with modern standards.

Due to the phased refurbishment programme and associated decant arrangements, the expanded footprint across Blocks A, B and C will not be fully operational until completion of the scheme, anticipated in 2030. Consequently, any revenue implications will not be realised until that time.

This provides the Health Board with several planning cycles to identify and agree a sustainable funding solution through future IMTP processes, affordability reviews and commissioner discussions before additional recurrent costs are incurred. Any future proposal to increase commissioned capacity beyond existing levels would require separate business case approval, commissioner agreement and identification of recurrent funding.

Overall Affordability

The anticipated capital spend, capital charges and depreciation profile for the programme of works are as follows:

	2026/27 £000	2027/28 £000	2028/29 £000	2029/30 £000	Total £000
Capital (Excl VAT) - DEL	280	11,582	9,363	8,964	30,189
VAT less reclaimable VAT	18	1,749	1,364	1,333	4,464
Total	**298**	**13,331**	**10,727**	**10,297**	**34,653**
Depreciation	0	0	113	184	231
Total	**0**	**0**	**113**	**184**	**231**

Executive Summary Table 15: Capital Impact on Income and Expenditure Account

All assets will be shown on the Health Board's balance sheet.

The asset will be valued on completion and recorded on the balance sheet at that value. Subsequently it will be treated as per the Health Board's capital accounting policy.

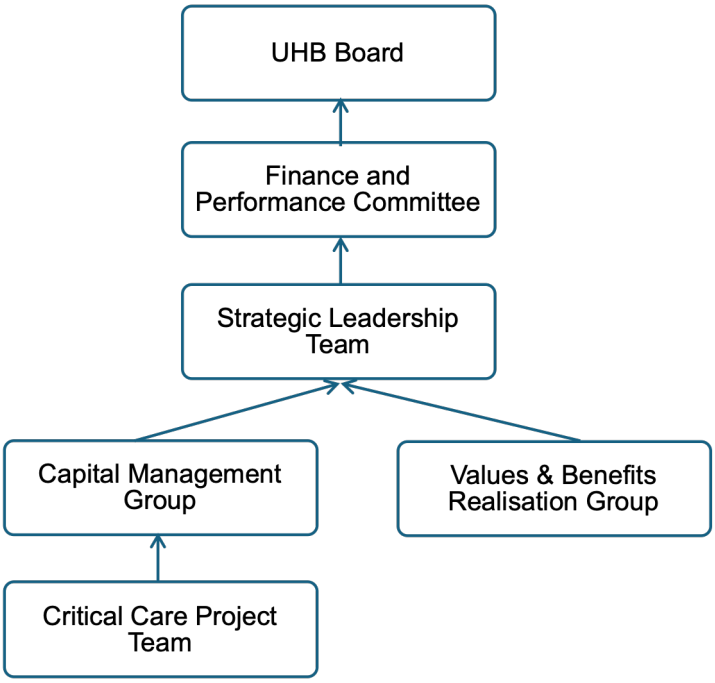
1.6 Management Case

Robust management arrangements are vital to ensure the implementation of the overall programme, and that effective control is maintained over the capital scheme.

In managing the programme, the Health Board aims to:

- Deliver the programme on time and to budget
- Ensure effective and proactive lines of accountability and responsibility for the programme deliverables, and
- Establish user involvement at all stages of the programme

The organisation and the reporting structure for the programme of works is shown as follows:



Executive Summary Figure 4: Programme Reporting Structure

The purpose of the structure is to manage and co-ordinate the programme. A programme / project team has been created and is responsible for the preparation of the programme business case and its subsequent projects.

Key project roles and responsibilities include:

Investment Decision Maker	CVUHB Board
Senior Responsible Owner	Director of Operations, Specialist Services Clinical Board, Jessica Castle
Programme Director	Director of Capital, Estates and Facilities, Geoff Walsh

Executive Summary Table 16: Project Roles and Responsibilities

The development of the scheme will also be supported by a range of corporate departments from within the Health Board including:

- Capital Planning
- Finance
- Strategic Clinical Engagement
- Workforce
- IM&T

Outline Programme Plan

The dates detailed below highlight the proposed key milestones of the programme:

Milestone Activity	Date
PBC submission to WG	November 2026
First BJC submission to WG	December 2026
Commence construction of Block C	January 2027
Construction completion of Block C	December 2027
Commence construction of Block B	December 2027
Construction completion of Block B	January 2029
Commence construction of Block A	January 2029
Construction completion of Block A	February 2030
Facility fully operational	February 2030

Executive Summary Table 17: Initial Programme Plan

It must be noted however that the above milestones are subject to the Wesh Government business case approvals process.

Benefits Realisation and Risk Management

Benefits are anticipated when a change is conceived and there are measurable improvements that result from the outcome which is perceived as an advantage by the organisation and/or stakeholders. Benefit management and realisation therefore aim to identify, define, track, realise and optimise benefits within and beyond the programme of works. It ensures that the programme is designed and managed in the right way to deliver quality and value benefits to patients, staff and local communities. A benefits realisation plan has been established that provides a framework for this aim and is overseen by the programme board.

The risk management strategy for the scheme has been integrated into the programme and project management procedures, with responsibility for implementation of the strategy resting with the programme director. A risk register has also been established and is subject to review and update on a regular basis.

Post Project Evaluation

The Health Board is committed to ensuring that a thorough and robust post-project evaluation (PPE) is undertaken at key stages in the process to ensure that positive lessons can be learnt. The Health Board has identified a plan for undertaking post- PPE in line with current guidance, which is fully embedded in the management arrangements of the scheme.

The outline arrangements for post implementation review and project evaluation review have been established and endorsed by the programme and relevant clinical board.

1.7 Recommendation

Failure to achieve business case approval at this stage would severely impact the ability of the Health Board to provide the necessary infrastructure required for the critical care unit at UHW. It is essential that the infrastructure of the unit remodels to ensure it meets patient demand, meets modern standards for prevention of cross infection and facilitates recruitment and retention.

Although future expansions may be required depending on the lifespan of critical care within UHW, there is a clear need now to expand the existing capacity for critical care, to at least meet 2028 requirements.

The programme business case presents a compelling case for the refurbishment of critical care to improve the physical facilities required to support the service for the short term and the Health Board therefore recommends that WG approve this programme business case in order to proceed to the next stage which includes the development of the business justification cases that support the phased refurbishment programme of works.

Report Title: *(needs to match agenda)*	UHB 148 Intellectual property rights policy update		Agenda Item No:		3.3
Meeting:	Finance and Performance Committee	Public	X	Meeting Date:	18 Nov 26
		Private			
Lead Executive Title:	Executive Medical Director				
Report Author/s Title:	Assistant Director of Innovation				

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

N/A

ADVISE *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

N/A

ASSURE *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

Intellectual Property Rights are described in law. Cardiff and Vale University Health Board Intellectual Property Rights policy (UHB 148) describes how the UHB will manage these rights. The policy has been updated to reflect current UHB organisational structure and in accordance with guidance issued in Welsh Health Circular 2026/004. The proposed new policy version (version 3) has been subject to input from UHB Innovation and R&D teams and expert review by NWSSP L&R team. All changes and recommendations have been incorporated.

Board/Committee Response Required ***(please select only one)***

To confirm the action Members are being asked to take considering the AAA Framework

Assurance		**Approval**	x	**Information/Noting**	

Recommendations

Recommendations should be clear, actionable, and aligned to the AAA summary above.

To approve and adopt UHB 148 Intellectual Property Rights Policy Version 3

Governance Route ***(please list all other Committee/Groups this report has been to)***

***Where** it's been:*	
***When** it went:*	
***What** decision was made:*	*e.g. Recommended to Board for approval*

Main Report

Background & Current Situation

Background

Intellectual Property Ownership and Rights are set out in law. However, the approach to local management and exploitation of such remains with the UHB.

The current Cardiff and Vale University Health Board (UHB) Intellectual Property Rights policy (UHB 148 Version 2) was last reviewed, approved and adopted on 16 Sept 2016.

Welsh Government issued a Welsh Health Circular (WHC) 2026/004 – "Refreshed Intellectual Property (IP) Guidance and Policies for NHS Wales Organisations" (March 2026) with a requirement for the UHB to "Resource, develop, embed, and implement a refreshed NHS Wales IP structure, policy and processes" by 20 Dec 2026.

Previous Welsh Government guidance dates from Feb 2005.

The WHC 2026/004 guidance is derived from the Department of Health and Social Care and NHS England refreshed guidance "Intellectual property (IP) guidance for the NHS in England" published 18 Nov 2025.

Current Situation

Based upon the current UHB structure and WHC 2026/004 guidance, an updated UHB 148 policy (Version 3) has been drafted with input from UHB Innovation and R&D teams.

Further review and input was sought from NHS Wales Shared Services Partnership Legal and Risk Services (L&R). Recommendations were made to update what was considered a traditional intellectual property commercialisation model to one that more fully reflects the patient benefit-led and innovation-management approach adopted by the WHC guidance (see below).

The review considered:

- *The Cardiff and Vale University Health Board Draft Intellectual Property Policy;*
- *The NHS Wales Intellectual Property Policy Template issued under WHC 2026/004;*
- *Consistency of approach, terminology and governance arrangements;*
- *Treatment of innovation, commercialisation, digital assets and artificial intelligence; and*
- *Alignment with the policy principles adopted across NHS Wales.*

***The review did not identify any material legal compliance deficiencies within the revised policy** and confirmed that it appropriately addressed:*

- *Ownership of intellectual property;*
- *Revenue-sharing arrangements;*
- *Disclosure processes;*
- *Research and collaboration arrangements;*
- *Management of intellectual property rights; and*
- *Commercialisation activities.*

But suggested narrative changes to support a broader innovation-management framework focused upon:

- *Patient benefit;*
- *Service improvement;*
- *Dissemination of innovation;*
- *Proportional commercialisation; and*
- *Flexible exploitation pathways.*

Further minor recommendations were made, that were primarily directed towards policy consistency, alignment and future-proofing.

L&R provided suitable text to support the core recommendations, and other consequential amendments, which have been fully incorporated into the new draft policy.

L&R confirmed that: ***Subject to implementation of the recommended amendments, the policy would be substantially aligned with the NHS Wales Intellectual Property Policy Template, whilst preserving the UHB's existing local governance arrangements, and would be suitable for adoption by the UHB.***

Recommendation: To approve and adopt UHB 148 Intellectual Property Rights Policy Version 3.

Appendices:
(List any appendices that will accompany this report).

Appendix A. UHB 148 Intellectual Property Rights Policy Version 3 (Draft)

Strategic Alignment – Shaping Our Future Wellbeing:
Please place an "X" against the strategic objective(s) this paper supports – Click the below tiles for further information.

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

Impact Assessment
Please ensure each section is completed. (If "Yes" is selected, complete the detail. If "No", please write "Not applicable".)

Risk: No

If yes, please include the details of any Risk Assessments undertaken and, where appropriate, the nature of any risks identified. (If this has been addressed in the main body of the report, please say so).

Safety: No

If yes, what are the Staff or Patient safety implications associated with the content/proposals within this report. Have these been fully considered and are plans in place to mitigate them? (If this has been addressed in the main body of the report, please say so).

Financial: No

If yes, what are the financial implications associated with the content/proposals within this report? Have these been fully considered and are plans in place to mitigate them? (If this has been addressed in the main body of the report, please say so).

Workforce: No

If yes, what are the workforce implications associated with the content/proposals within this report? Have these been fully considered and have plans been put in place to mitigate them? (If this has been addressed in the main body of the report, please say so).

Legal: No

If yes, what are the legal implications that arise from the content/proposals within this report? Has advice been sought and what was the outcome? (If this has been addressed in the main body of the report, please say so).

Reputational: No

If yes, what reputational risks are associated with the content/proposals within this report? Have these been fully considered and have plans been put in place to mitigate them? (If this has been addressed in the main body of the report, please say so)

Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*

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

Equality & Health: No

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

Decarbonisation: No

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

- *A focus upon preventing ill health in our population*
- *Saving energy or increasing throughput.*
- *Value based healthcare.*
- *Patients empowered to manage their conditions, utilising See on Symptoms and Patient Initiated follow ups to reduce unnecessary appointments.*
- *Service delivery in the most appropriate setting*
- *Reducing waste*

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

Welsh Language: No

Consideration should be given to potential impact on the Welsh language

- *Does the report align with the More than just words strategy, ensuring Welsh-speaking patients can access services in their preferred language?*
- *Ensure key information is bilingual and that the report meets the Welsh Language Standards for communication, signage, and patient materials.*
- *Does the report address the need for Welsh-speaking staff or bilingual resources to deliver equitable care?*

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

Appendix 1 – UHB 148 Intellectual Property Rights Policy Version 3 (Draft – for approval)

Reference Number: UHB 148 **Version Number:** 3	**Date of Next Review:** 18 Nov 2029 **Previous Trust/LHB Reference Number:** N/A

INTELLECTUAL PROPERTY RIGHTS POLICY

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we provide guidance on the identification, referral and processes involved in securing, exploiting and commercialising intellectual property rights generated by staff employed by the UHB, to include those on honorary contracts or contractors working on behalf of the UHB.

Policy Commitment

We are committed to ensuring that the legal framework governing Intellectual Property Rights (IPR) is available, understood and adhered to by our staff and those with honorary contracts and contractors working on behalf of the UHB. Preservation of IPR for patient and societal benefit, teaching, research and other non-commercial purposes is a cornerstone of this policy. The purpose of the policy is to protect the UHB and activities arising from activities undertaken by staff working at the UHB, to include those with an honorary contract* (please see note below for Clinical Academics working on a Service Level Agreement between Universities and the UHB) or independent contractors working on behalf of the UHB, in which the UHB has a legitimate interest.

* *Clinical Academics, employed by a University and providing clinical sessions to the UHB are employed to perform research in the University, and in most instances intellectual property will belong to the University. However, it is acknowledged that ideas vary in origin and application to clinical practice also varies, therefore clinical innovation opportunities arising from this staff group will be reviewed on a case-by-case basis to best determine IPR ownership.*

Supporting Procedures and Written Control Documents

This Policy and the supporting procedures describe the following with regard to IPR

- The legal framework within which intellectual property may be protected and commercially exploited.

Other supporting documents are:

- Welsh Health Circular 2026 (004) – 'Refreshed Intellectual Property (IP) guidance and policies for NHS Wales organisations' (Replacing Welsh Health Circular 2005 (010) – 'A framework and guidance on the management of intellectual property in the NHS in Wales')
- 'The Rose Book: Knowledge asset management in government' (2021; updated 2024)

- 'Guide to Managing Intellectual Property and Confidentiality' – Government Office for Technology Transfer (2023)
- Department for Health and Social Care IP guidance for NHS England (Nov 2025)
- 1977 Patents Act
- 1988 Copyright, Designs and Patents Act
- 1984 Trademarks Act
- 1997 Copyright and Rights in Databases Regulations
- 1949 Registered Designs Act
- 2022 Subsidy Control Act
- 1998 Competition Act
- 2023 National Security Act
- 2013 HMG Security policy framework: protecting government assets (updated 2022)

Scope

This policy applies to all of our staff in all locations including those with honorary contracts and contractors working on behalf of the UHB seeking to secure IPR, including exploitation to generate income from any commercial activity in their working time, and/or activity arising from their work association with the UHB, in which the UHB had a legitimate interest.

Equality Impact Assessment	An Equality Impact Assessment (EqIA) was completed in 2016 and this found there to be no adverse impact. Circumstances remain unchanged.

Health Impact Assessment	A Health Impact Assessment (HIA) is not required for this policy.
Policy Approved by	Finance & Performance Committee
Group with authority to approve procedures written to explain how this policy will be implemented	R&D Research Management Board (proposed)
Accountable Executive or Clinical Board Director	Executive Medical Director
Author	Assistant Director of Innovation

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or Governance Directorate.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Approved by the Strategic Planning and Performance Committee 23/10/2012	30/11/2012	
2	Performance Committee People, Planning and	08/11/2016	Revised document to include: • Reference to the Clinical Innovation Partnership with Cardiff University and the introduction of a multi-disciplinary team to support ideas development and exploitation; • Clarification of IPR for Clinical Academics with a UHB honorary contract; • Removal of reference to the Director of Innovation and Improvement and inclusion of the Executive Lead for Clinical Innovation and the Associate Medical Director for Clinical Innovation reflecting the current managerial arrangements for clinical innovation; • Removal of reference to the Commercial Advisory Panel as this panel no longer exists; • Broadening of the definition of Copyright • Explicit reference to Cardiff University • Inclusion of Case Studies to guide staff on IPR as an employee of the UHB
3	Finance & Performance Committee	18 Nov 2026	Revisions made for clarity and to align with UHB structure and recommendations from Welsh Health Circular WHC/2026/004 Appendix 2 to move towards closer alignment and harmonisation of similar policies across the NHS Wales NWSSP L&R review recommendations introduced. Additional appendices (for information) added.

CONTENTS

SECTION **PAGE NO.**

1. INTRODUCTION 5
2. AIM 5
3. SCOPE 6
4. DEFINITIONS AND LEGAL CONTEXT 7
5. ROLES AND RESPONSIBILITIES 11
6. PRINCIPLES FOR THE MANAGEMENT, DEVELOPMENT AND COMMERCIALISATION OF INTELLECTUAL PROPERTY 13
7. OWNERSHIP AND DISPUTE RESOLUTION 16
8. ROYALTY INCOME AND REVENUE SHARING 21
9. ASSUMPTION OF LIABILITIES/INDEMNITIES 23
10. RESOURCES AND USE OF TTOs 23
11. TRAINING 26
12. IMPLEMENTATION AND COMPLIANCE 26
13. EQUALITY STATEMENT 27
14. MONITORING AND REPORTING 27
15. DISTRIBUTION 28
16. REVIEW 28
17. APPENDIX A – CASE STUDIES 29
18. APPENDIX B – INNOVATIVE IDEAS DISCLOSURE FORM 33
19. APPENDIX C – INTELLECTUAL PROPERTY PROTECTION 36

1 INTRODUCTION

This policy gives guidance on the identification, referral and processes involved in securing, exploiting and commercialising of intellectual property rights (IPR). In addition, the policy provides a framework for the conduct, management and reporting of the progress with these activities and resulting income generation, which must not, in any way, interfere with the Health Board's core healthcare business.

2 AIM

Preservation and appropriate exploitation of intellectual property (IP) rights for patient benefit, teaching and research, and other non-commercial purposes, is a cornerstone of this policy.

Cardiff and Vale University Health Board (UHB) aims to secure and extract value, including wealth creation, through appropriate protection and management of the knowledge, inventions and technology generated internally, including from its innovation, service improvement, teaching and research and development programmes. This includes the ownership and management of IP arising from collaborative projects with other organisations, e.g. universities, or other third parties. The policy aims to ensure that ownership of IP is established at an early stage and that the responsibilities of all staff and management are clear, including those holding honorary/consultancy contracts with the UHB, with a transparent process to resolve disputes. The policy describes the approach to the apportionment of revenue from any profits of commercialisation activity and the process to implement revenue sharing.

It is the intention of this policy to:

- Ensure that IP is identified, protected, managed and utilised in a manner that maximises patient benefit, service improvement and public value across NHS Wales.
- Support the dissemination and adoption of innovation throughout NHS Wales where such dissemination represents the most appropriate means of achieving clinical, operational or public benefit.
- Support the proportionate protection, development and commercialisation of IP where such activity is consistent with the principles set out in Section 6.
- Support collaboration with NHS organisations, universities, research institutions, charities, Technology Transfer Offices (TTOs) and commercial partners to maximise the value derived from innovation.

3 SCOPE

The policy applies to all Cardiff and Vale UHB employed staff, including staff on honorary contracts* (when IP develops from some of the contracted time) and contractors working on behalf of the UHB, seeking to exploit IP from any research, innovation or associated commercial activity in their working time, and/or activity arising from their work association with the UHB, in which the UHB has a legitimate interest. This includes staff with UHB contracts of employment whose payroll costs are partially or fully funded by another party (e.g. academic institution, medical charity, Government department or commercial entity) unless the contract between the UHB and that party assigns ownership of the IP to that party.

IP generated during education or training which is funded by the UHB, especially if the UHB also contributes towards creation of IP by, for example, acting as sponsor of the research in accordance with the UK Policy Framework for Health and Social care research, is included. However, trainee professionals and students hosted by the UHB, who are not employees of the UHB, but who generate IP during their training may not be covered. IP generated by students engaging in research for the UHB may be owned by the student, or the institution with whom they are enrolled, or the UHB, depending on the agreements between the student, the institution and the UHB.

** IPR arising from staff holding honorary contracts with the UHB, e.g. Clinical Academics, will be reviewed on a case-by-case basis.*

Note:

Independent providers of services who generate IP from research funded by the NHS are required to inform the appropriate party and share the benefits of its commercialisation. Where IP is assigned to the UHB, the Independent Provider of Services will benefit under the revenue sharing scheme of the UHB. For individuals who hold an Honorary Contract with the UHB, the IP Policy of their substantive employer will take precedence over the UHB's policy unless circumstances require negotiation to the contrary to ensure the UHB's contribution is fairly rewarded. For example, where the honorary employee has utilised funding, UHB equipment, consumables or the time during UHB funded sessions or of UHB-funded staff to create the IP would likely require acknowledgement of the UHB's contribution to the creation of the IP.

UHB staff seconded to another organisation or employees of another organisation hosted by the UHB under contract are subject to the terms defined in the contract between the UHB and that organisation and/or subject to a person's employment contract or any other terms upon which a person is engaged by the UHB.

Private practice originating IP generated during self-employment by employees working outside the course of their employment with the UHB is not covered by this policy. Employees are reminded of their obligations to preserve the confidentiality of IP of the UHB.

IP generated as a result of contractual relationships, e.g. including but not limited to, contracts with large pharmaceutical companies, medical device companies, service providers and start-ups, should have IPR allocation described within the associated contract(s).

4 DEFINITIONS AND LEGAL CONTEXT

Intellectual property is a collective term referring to creations of the mind. IP can be defined as the products of intellectual or creative activity in the form of novel ideas, innovation or research & development - that can be given legal recognition of ownership. IP can be generated where R&D, innovation, care delivery or management, or other creative works are being undertaken. A brief overview is outlined below. See Appendix C and policy referenced supporting documents for more detail.

Types of Intellectual Property

IP can be assigned or licensed exclusively or non-exclusively and can be generated where R&D, innovation, care delivery or management, or other creative works are being undertaken.

For example:

- Acts of research, development and / or innovation
- Things you write, make or produce
- The design or look of products
- The names of products or brands
- Proprietary knowledge (know-how)

NHS Wales organisations and their staff generate, use, and manage IP daily through research, innovation and service delivery. This IP includes, but is not limited to:

- The extensive know-how of NHS Wales staff
- Training materials and toolkits
- Innovations created with NHS Wales resources (people and infrastructure)
- NHS Wales-generated data, databases and methodologies, including annotated imaging data and outcomes measures
- New medical devices, software, diagnostics, medicines, techniques and information resources.

Protection of Intellectual Property

Intellectual property protection is the legal mechanism that provides protection for acts of innovation and creativity, which in turn gives rise to IPR.

These IP rights formalise the ownership of IP. While some IPR such as patents, trademarks, and registered designs are obtained through formal registration, unregistered IP such as copyright and unregistered designs receive automatic protection to prevent others from copying them without the owner's permission.

Other examples of unregistered IP such as know-how, processes, and trade secrets are protected through appropriate confidentiality and contractual mechanisms rather than registration. It should be noted that IP legislation is complicated and the scope of IP rights (what can be protected and what cannot be protected) is often a grey area. Members of staff are advised to contact the R&D or Innovation teams at the earliest opportunity.

IP can be owned, assigned, licensed, or shared, under different arrangements. IP can be generated where R&D, innovation, delivery or management of care or other creative work is being undertaken. During the application process for a patent, it is imperative that the invention documentation remains confidential. Prior disclosure of this information will render the invention non-patentable in almost all regions of the world. While IP can and often does arise from formal research projects, it is not limited to the outputs of research studies and can be generated in many other ways. For example, IP may arise as a result of staff trying to find a solution to a problem, developing innovative teaching or training materials or designing a new device based on their experience while working with other staff and patients.

Commercialisation

The process of developing, licensing, assigning, marketing, disseminating or otherwise exploiting IP or innovation for the purpose of achieving patient benefit, service improvement, public value and/or financial return.

Innovation

Any new or improved product, service, process, pathway, technology, method, software solution, educational resource or other development capable of creating value.

Technology Transfer Office (TTO)

Any internal or external organisation engaged to support the identification, protection, management, development or commercialisation of IP.

Digital Asset

Any software, algorithm, application, dataset, database, digital platform, artificial intelligence-enabled solution or other electronically stored asset capable of generating IPR or other value.

Know-how

Technical knowledge, expertise, methodologies, processes, practices and information that may not be formally protected by registered IPR.

Both the 1977 Patents Act and the 1988 Copyright Designs and Patents Act state that, where IP is generated during the normal course of an individual's employment, such IP shall belong to the employer. In addition, the 1977 Patents Act states that where IP is generated following the exercise of duties assigned to staff and the creation of an invention was reasonably expected or there was an obligation to further UHB's interests, such IP shall belong to the employer.

With a view to supporting and accelerating health and wealth creation in Wales it is UHB policy to actively and collaboratively engage with its staff in identifying, developing and exploiting IP to the mutual benefit of the originator of the IP, the Welsh community and the UHB. The UHB has therefore taken the decision to exercise its legal right to own IP and to ensure that the originator of the IP is fairly compensated, as outlined below.

Any document that is produced will need to deal with the issue of the ownership of existing IPR or those rights created during the commercial enterprise. As mentioned, and for the aforementioned reasons, it is the UHB's position that any IPR created during the normal course of an individual's employment or following the exercise of the above-mentioned duties will belong to the UHB.

Employees have an obligation to inform the UHB about IP generated as a result of their activities and must not sell, assign or otherwise trade IP without the UHB's agreement.

In the instance where the UHB is unable to exploit IPR, and it is able to do so, it may offer them to the originator of the IPR for him/her to exploit. Any document entered in to by the UHB should make specific reference to these points. In return for the assignment, the inventor(s) may be asked to share a small percentage of any income generated with the UHB. Additionally, the UHB will retain the right to use the work at no cost for its own non-commercial purposes.

Ideas disclosure and Record Keeping

Employees should disclose all potentially valuable innovations and intellectual assets arising from their activities, irrespective of whether immediate commercial potential has been identified.

Such disclosures may include:

- Inventions;
- Software and applications;
- Algorithms;
- Artificial intelligence-enabled solutions;
- Datasets and databases;
- Medical devices;
- Diagnostic methods;
- Treatment pathways;
- Educational resources;
- Service redesign methodologies;
- Digital transformation initiatives;
- Process improvements; and
- Other innovations capable of generating value for patients, NHS Wales or the wider public sector.

Disclosure should occur at the earliest practicable opportunity and, wherever possible, prior to publication, public presentation, commercial discussion or external disclosure.

A standard Ideas Disclosure Form template for staff and personnel to submit their ideas, which will then be considered by the UHB, can be found in Appendix B.

The UHB will work with staff to evaluate the potential of the IP and create a forward plan for its management and exploitation if that is appropriate.
The Ideas Disclosure Form asks the person disclosing the IP to detail their idea, explain its originality/inventiveness and how it can benefit the health service, and patients, either directly or indirectly. Receipt of the Ideas Disclosure Form will be used to initiate tracking and management of the idea.

Any disclosure made to the UHB, e.g. through the Ideas Disclosure Form, is deemed as a confidential disclosure and will be kept confidential.

In seeking to establish the originality/inventiveness of an idea staff may wish to investigate it online. Where appropriate, the R&D and Innovation teams will aim to support such searches, e.g. patent searches in the case of technical ideas. It is re-emphasised that staff should not disclose their idea to anyone apart from research collaborators with whom they are bound by a viable contract which

includes provisions for confidentiality, as this might jeopardise subsequent IP protection. Staff are asked to consult the R&D and Innovation teams at an early stage if they have any questions about this and especially if they are uncertain about the implications of disclosing an idea to others.

Record Keeping

It is essential that staff working on projects that are likely to generate IP keep detailed written and dated records of their activities and results.

It is imperative that all correspondence, including emails, telephone conversations and meetings are logged to provide a detailed account of any discussions relating to the IP. In general, good record keeping is a fundamental requirement of good clinical practice and research governance.

5 ROLES AND RESPONSIBILITIES

The UHB's Finance & Performance Committee shall approve this policy, which incorporates:

- Procedures to encourage and assist staff to maximise the commercial exploitation of inventions and processes resulting from innovation and research carried out at the UHB.
- Procedures to deal with any IPR and investments in spin out companies accruing to the UHB from inventions and discoveries made by staff in the course of their activities (including IPR generated through the funding of other organisations, e.g. NIHR, that obliges the UHB to own the IP as the term of a funding contract).

The Executive Medical Director is the Executive Lead who in conjunction with other senior and Executive colleagues, including the Executive Finance Director are responsible for supporting patents and other IPR on behalf of the UHB.

Staff Responsibilities

Employees must engage with the University Health Board's innovation management processes at the earliest practicable opportunity where they believe an innovation, invention, software solution, dataset, digital asset, educational resource or other potentially valuable IP has been created.

Innovation and Research Functions

The UHB Innovation and R&D teams will support the development of the research and clinical innovation ideas/service improvements in line with the overarching

principles focussed on developing, translating and deploying evidence for patient and societal benefit.

Responsibilities include:

- Ensuring that appropriate commercial and professional advice is provided and/or obtained where necessary to aid the development and translation of the idea, where appropriate;
- Providing independent advice on proposed commercial transactions such as patents, licenses and commercial opportunities;
- Devise suitable strategies and opinions with a view to make recommendations to the Management Executives on the translation, adoption and procurement, where appropriate, of ensuing products/technologies/services.

Assessment of Development and Exploitation Pathways

The Innovation and Research & Development functions shall assess disclosed innovations and make recommendations regarding the most appropriate route for development and exploitation having regard to the principles set out in Section 6.

Such recommendations may include:

- Dissemination and adoption without commercialisation;
- Assignment or licensing to innovators or third parties;
- Collaborative development arrangements;
- Strategic commercialisation;
- Creation of spin-out or joint venture arrangements; or
- Any combination of the foregoing.

Technology Transfer Support

The University Health Board may engage internal or external TTOs, patent attorneys, IP specialists, legal advisers, valuation specialists and commercial advisers to support the assessment, protection, development and exploitation of IP.

All commercial exploitation activity is managed by the Executive Medical Director in accordance with UHB governance and oversight processes. The formal procedures for approving the establishment of any new enterprises that are related to the UHB, and its activities, will be in accordance with the general principles set out in section 6 below.

Ultimate decision-making responsibility regarding IPR rests with the Chief Executive of the UHB.

6 PRINCIPLES FOR THE MANAGEMENT, DEVELOPMENT AND COMMERCIALISATION OF INTELLECTUAL PROPERTY

6.1 General Principles

The UHB recognises that IP may arise from research, innovation, service improvement, clinical practice, education and training activities, digital transformation initiatives, the application of artificial intelligence technologies, and the development of new products, processes, services, software, data assets and know-how.

The primary objective of the UHB's approach to IP is to maximise benefits for patients, service users, the public and NHS Wales. Whilst commercialisation may provide an opportunity to generate income, commercial return is not an end in itself and should support the wider objective of improving healthcare outcomes, service delivery and public value.

The UHB will seek to identify, protect, manage and exploit IP in a manner that:

- Promotes innovation and continuous improvement;
- Supports patient benefit and service transformation;
- Secures appropriate recognition and reward for contributors;
- Protects public assets and investments;
- Facilitates collaboration with academic, public and commercial partners;
- Complies with applicable legal, regulatory and contractual obligations; and
- Secures an appropriate and proportionate return where NHS resources have contributed to the creation, development or exploitation of IP.

6.2 Assessment and Decision-Making

The UHB will consider each innovation and IP opportunity on its individual merits.

In determining how IP should be managed, protected or exploited, the UHB may take account of:

- The anticipated benefit to patients, service users and NHS Wales;
- The strategic importance of the innovation;
- The UHB's, collaborator's or third party's contribution to its development;
- The contribution made by the UHB, including funding, facilities, staff time, clinical expertise, data, equipment and other resources;
- Applicable contractual, funding and regulatory requirements;
- The feasibility of protection, development and commercialisation;
- Market opportunity and potential demand;

- Risks associated with development and exploitation; and
- The anticipated costs and benefits of protection and commercialisation.

The UHB may decide that the most appropriate outcome is dissemination and adoption of an innovation for patient benefit without pursuing formal IP protection or commercial exploitation.

6.3 Routes for Development and Exploitation

The UHB recognises that there is no single model for exploiting IP and that different approaches may be appropriate depending upon the nature of the innovation.

The UHB may adopt one or more of the following approaches:

Route 1: Adoption and Dissemination

The UHB may elect to support the adoption, sharing or dissemination of an innovation where this is likely to maximise patient benefit, improve healthcare delivery or support NHS Wales objectives, without seeking commercial returns.

Route 2: Assignment or Independent Development

Where appropriate, the UHB may assign or license IPR to inventors, collaborators or third parties, subject to such terms as it considers appropriate to protect NHS interests and secure a fair return where justified.

Route 3: Strategic Development and Commercialisation

The UHB may actively participate in the development, protection, licensing or commercialisation of IP where this is likely to generate significant patient benefit, strategic value or financial return.

Such arrangements may involve partnerships with universities, public-sector organisations, charitable organisations, TTOs, investors or commercial organisations.

6.4 Partnerships and Commercialisation

The UHB encourages collaboration with academic institutions, research organisations, industry partners and other public bodies in support of innovation.

Where IP is developed jointly with third parties, ownership, management and exploitation arrangements should be addressed through appropriate contractual documentation at the earliest practicable opportunity.

Commercialisation arrangements may include, without limitation:

- Licences;
- Assignments;
- Collaborative development arrangements;
- Revenue-sharing arrangements;
- Joint ventures;
- Consultancy and service agreements; and
- The formation of new corporate entities.

The UHB will seek to ensure that any commercial arrangements are proportionate, appropriately governed and represent value for money.

6.5 Technology Transfer and Specialist Support

The UHB may utilise internal expertise and external specialist advisers to support the protection, valuation, development and exploitation of IP.

Such support may include engagement with TTOs, patent attorneys, IP specialists, legal advisers, commercial advisers and other professional advisers as considered appropriate.

The costs associated with obtaining professional advice and IP protection shall be considered as part of each individual business case.

6.6 Creation of Companies and Spin-Out Ventures

In circumstances where the UHB determines that the establishment of a separate company represents the most appropriate means of developing or commercialising IP, the UHB may participate in the formation of a spin-out, joint venture or other corporate vehicle.

Prior to approving such arrangements, the UHB shall consider:

- The strategic rationale for the proposal;
- Expected patient and public benefit;
- The contributions of all participating parties;
- Governance and conflict-management arrangements;
- Financial and reputational risks;

- Exit arrangements; and
- Compliance with applicable legal and regulatory requirements.

The UHB may hold shares or other interests in such entities where this is considered appropriate and lawful.

6.7 Conflicts of Interest

All employees, office holders, volunteers, students and other individuals engaged by the UHB must declare any actual, potential or perceived conflict of interest arising from their involvement in the creation, development or commercialisation of IP.

Any such conflicts shall be managed in accordance with the UHB's Conflicts of Interest Policy and any other applicable governance procedures.

6.8 Governance

Responsibility for oversight of IP management and commercialisation shall rest with the Executive Medical Director (or such successor officer as may be designated by the UHB), supported by appropriate innovation, research and development, finance, legal and commercial advisors. Ultimate decision-making responsibility rests with the Chief Executive.

Decisions concerning the protection, assignment, licensing or commercialisation of IP shall be taken in accordance with the UHB's Scheme of Delegation, Standing Orders, Standing Financial Instructions and other applicable governance arrangements.

All activity must be conducted in accordance with the UHB's Income Generation Governance and Ethical Framework.

7 OWNERSHIP AND DISPUTE RESOLUTION

Ownership Principle

Ownership of IP shall be determined in accordance with applicable law, contractual arrangements, funding conditions and the principles set out in Section 6 of this Policy.

The ownership of IP can be a complex issue and subject to misunderstanding. The UHB will work with all members of staff in an open and transparent manner to ensure that they fully understand all the implications regarding ownership of IP

and all the options available to them so that their best interests are served. The UHB will endeavour to ensure that innovations are developed for maximum patient benefit and that those staff who made an intellectual contribution to the innovation receive tangible benefits in reward for their contribution.

Patents, copyright, design rights and possibly know-how created in the normal course of employment belong to the UHB or inventions created following the exercise of duties assigned to staff where creation of an invention was reasonably expected or there was an obligation to further UHB's interests, belong in law to the UHB.

The UHB has taken the decision to own and engage with its staff in exploiting its IPR, as a consequence, employees as part of their contracts of employment, undertake (or should be asked to undertake if this is not the case) not to disclose information which has arisen as a result of their duties of employment without approval of the UHB. This approval will not be unreasonably withheld but may be deferred whilst valuable IPR are applied for or registered. External organisations involved in projects will be required to sign Non-Disclosure Agreements (NDAs).

Students

The term 'students' can encompass a variety of roles within the NHS. The following general principles typically apply but note that this is not exhaustive and judgement will be required.

Undergraduate students

Undergraduate students will retain ownership of any IP they create, as they are not employees of the UHB. While apprentices are usually employed and subject to an employment contract, their academic work may be subject to the IP policy of an academic organisation and therefore owned by the apprentice.

Postgraduate students

If a postgraduate student is employed by the UHB, IP rights are typically governed by the terms of their employment contract. If they are self-funded, ownership arrangements may vary. Consideration should be given to the nature of the work and whether it would be more appropriate for the IP to vest with the UHB or remain with the student.

Secondees and honorary contracts

IP created by secondees or people working on honorary contracts will not automatically be owned by the UHB unless this has been specifically agreed with the secondee's or honorary contract holder's employer or institution. The

agreements between organisations in these cases should specify who owns the IP created in which circumstances.

Funded Research and Activity

Where IP arises from activities funded by another organisation, the UHB may be required to assign such IP to the funding organisation under the terms of the relevant funding agreement. Where external funding is received, the University Health Board shall ensure that any IP obligations contained within the relevant funding terms and conditions are identified and appropriately managed.

Collaborations and Collaborative Projects

Where IP is generated through collaboration with a university, NHS organisation, commercial organisation, charity, research funder or other third party, ownership, management and exploitation arrangements should be agreed in writing at the earliest practicable stage of the project and prior to commencement of activity.

Such arrangements should, where appropriate, address:

- Ownership rights and arrangements;
- Exploitation strategy;
- Licensing rights and arrangements;
- Publication rights and arrangements;
- Revenue-sharing arrangements;
- Protection strategies;
- Commercialisation responsibilities;
- Use of data;
- Artificial intelligence governance;
- Management of confidential information; and
- Exit arrangements.

Private practice

Originating IP generated during self-employment by employees working outside the course of their employment with the UHB is not covered by this policy. They are reminded of their obligations to preserve the confidentiality of IP of the UHB. If a member of staff wishes to develop an idea they have conceived on their own which clearly lies outside their role in the UHB they are free to do that (subject to any conflicting terms in their contracts of employment) but it is advised that they consult the R&D or Innovation teams so that both they and the UHB are clear about the potential consequences for both. The UHB sees itself as a partner in helping staff develop their ideas even if they were developed outside the remit of their employment. The R&D or Innovation teams may be able to help improve the employee's chances of making progress with their ideas, for example by helping

staff secure the necessary funding, using the UHB innovation management resources and being able to test the innovation in the NHS.

Suppliers and contractors

Unless a contract for services states otherwise, IP created by contractors will be owned by them, not the UHB. In some cases, where the UHB is paying for IP to be developed (sometimes called foreground IP) it will be appropriate for the contract to assign ownership in that IP to the organisation. However, it is reasonable for the contractor to retain ownership of anything it created prior to or unrelated to the contract (background IP). If the UHB needs to use IP owned by the contractor that is not assigned to the UHB it should be licensed to the UHB in the contract.

Copyright

Copyright is likely to be the most common area of IPR (which arises from research/innovation activities, for example the creation of manuals, reports, software development etc.).

There is no need to register copyright, unlike the need to register other forms of IPR. Copyright arises automatically and is effective as soon as something that can be protected is created and "fixed" in some way, e.g. on paper, on film, via sound recording, as an electronic record on the internet, etc.

Employees should mark their copyright work with the copyright symbol © followed by “Cardiff and Vale University Health Board” and the date, to warn others against copying it, but it is not legally necessary in the UK.

The UHB will have the discretion to transfer ownership of the copyright to the author of the work although the UHB should have the right to use the work at no cost for its own non-commercial purposes. However, the UHB may wish to retain the copyright for some items, for example:

- Course or training material;
- Patient information leaflets;
- Software programmes;
- Designs specification/protocols;
- Photographs or other images; or
- Other works which may be necessary to protect rights in commercially exploitable IP.

Under the Copyright, Designs and Patents Act 1988, the author (other than an employee in relation to works generated in the course of their duties of employment) is entitled to assert their moral rights in respect of the work created even where ownership is vested in a third party such as the Organisation. This

means that the author is entitled to have the integrity of the work respected, which would include the way in which it is used and the context in which it is included.

If an employee thinks it would be of mutual interest and of benefit to patients and society to have the copyright in their work transferred (assigned) to them, they should contact the Innovation team in the first instance.

Shared Materials

Materials are defined as equipment, reagents and biological materials, including cell lines, tissues, bacterial strains, plasmids and viruses. When such materials are distributed to other researchers, or used in a project, they should be subject to a Material Transfer Agreement (MTA) which will be managed via the relevant UHB R&D and Innovation teams. This agreement should define the limitations of use of the material and recognises the interest in the IP that may arise from its use. This agreement must be in place prior to distribution and use of the material. The use of trademarks and design rights associated with the aforementioned materials should also be the subject of this agreement.

Dispute resolution

Where there is dispute about the inventor(s) of IP, dated written records associated with the generation of the IP will be used to establish the inventor(s) of the IP and to determine their level of contribution/remuneration. In the absence of documentary evidence, the Chief Executive of the UHB shall decide, taking such professional advice as appropriate and this decision will be final.

An employee who believes the UHB has wrongfully claimed ownership of IPR shall seek resolution by means of the All Wales Respect and Resolution Policy (heiw.nhs.wales/files/respect-and-resolution-policy-final-april-2021/).
Advice will be available to transfer the IPR to the UHB when this is agreed to be necessary. Without transfer of the IPR, NHS Wales resources will not be available to the employee to exploit the IPR.

Where external organisations are involved, formal legal advice should be sought by the UHB and the costs of such advice will be borne by the party seeking it. The final decision will be final and binding on all parties involved.

Use of IP Owned or Controlled by a Third Party

Note that where the UHB wishes to use IP belonging to a third party (which may include another NHS organisation):

- The UHB should not use IP belonging to third parties without the express permission of that organisation. All agreements for the UHB to use third party-owed IP must be documented by a written contract which includes a clause dealing with the ownership of IP.

- Use or copying of any materials for which the IP is owned or controlled by a third party without permission may be an infringement of that third party's IP rights. The unauthorised use of IP creates legal, financial and reputational risks for the UHB.
- Staff who become aware of any infringement or alleged infringement of any IP should report it to the necessary point of contact within the UHB.

AI, Software and Digital Assets

For the avoidance of doubt, this Section applies equally to software, algorithms, machine learning models, artificial intelligence-enabled solutions, datasets, databases, digital platforms, decision-support tools, educational resources and other digital assets capable of attracting IP protection.

8 ROYALTY INCOME AND REVENUE SHARING

The University Health Board recognises that many innovations may deliver substantial value through service improvement, patient benefit, adoption across NHS Wales or wider societal benefit without necessarily generating direct commercial income.

Nothing in this Section shall require the commercialisation of an innovation where dissemination, adoption or implementation for public benefit is considered to be the most appropriate outcome.

Revenue-sharing arrangements shall be applied having regard to the principles contained in Section 6 and the particular circumstances of each innovation.

The UHB share of royalty income is utilised to offset the costs of securing, managing and maintaining IPR as well as to the wider benefit of the UHB and population that it serves.

Income from the successful commercial exploitation of IPR, through the transfer of IPR by assignment or licensing, receipt of dividends or profit shares or ownership of shares will normally be received by the UHB. As an incentive to employees, the UHB will normally grant employees and their respective departments an interest in revenues from the successful exploitation of IPR. The R&D and Innovation teams, working with appropriate senior and Executive Operational, Clinical and Financial colleagues, and after taking external expert advice (where required), are responsible for recommending income sharing arrangements on each project to the Chief Executive. In all cases the shared revenue will be the net income attributed to an IP right minus any relevant costs incurred by the UHB in bringing the product to market, e.g. internal costs, patenting or registration fees, and other legal and marketing costs. The UHB, exercising probity, will administer and calculate income arising from IP commercialisation.

Where there is a contracted agreement with a funding sponsor to share revenue from successful exploitation of IP arising from research funded by that sponsor, the cumulative net revenue to the UHB is the income from exploitation remaining after deduction of the sponsor's share and other costs as above.

Where a university or other higher education institution(s) leads on the project then, unless there are special circumstances, the UHB will adopt the same cumulative net revenue sharing (after considering relevant costs) as agreed with that organisation(s).

Where the UHB leads on a project then independent commercial advice should be obtained for all major projects (potential income in excess of £100,000).

The allocation of royalty income will depend upon the complexity and size of the project. As a starting point the allocation outlined in the Welsh Health Circular WHC 2026 (004) and outlined in the table below will be used.

Cumulative net income	Inventor	Department	IP Support Team	Organisation
First £10K	100%	0%	0%	0%
£10K-£20K	60%	20%	10%	10%
£20K-£100K	50%	20%	15%	15%
£100K-£250K	40%	20%	20%	20%
Over £250K	35%	20%	15%	30%

Where the employee produces more than one item of IP, the income from subsequent IP - unless the subsequent IP is unrelated - will be aggregated with that from the first IP for the purpose of determining the employee's share according to the sliding scale of net revenue.

Where there are multiple inventors, the attributable share will be shared between them, in a proportion that is fair and reasonable given the contribution made by each of the Inventors. These payments are subject to tax.

The inventor’s (or inventors’) share of net revenue is intended to continue beyond employment with the UHB and until the death of the inventor or the expiry of the licence agreement, whichever event occurs sooner and thereby revert to the UHB.

If an inventor does not claim their share or the net revenue for a period of 12 months from the date when the UHB makes it available to an inventor, then the UHB may retain this revenue (and any interest). The UHB may distribute this revenue to any other inventors at its discretion.

If an inventor leaves their employment with the UHB due to misconduct, then the payment of any revenue share will be at the discretion of the UHB and there will be no automatic entitlement after the date of termination of employment.

Note: Where shares are to be issued or outside investors are involved then the allocation is more complex and should be determined using professional advice.

9 ASSUMPTION OF LIABILITIES/INDEMNITIES

The basis of assumption of liabilities/indemnities will be set out in each project and adequate indemnity/insurance cover provided for where necessary. In certain instances, the UHB may seek legal advice to confirm the UHB's liabilities to include financial, IP warranties or breach of third-party party IPR for example.

10 RESOURCES AND USE OF TECHNOLOGY TRANSFER OFFICES

Specialist Support

The University Health Board may utilise internal expertise and external specialist support to assist in the identification, protection, valuation, management, development and exploitation of IP.

Technology Transfer Offices and Advisers

TTOs, also referred to as Technology Transfer Capabilities, can provide valuable support to NHS Wales organisations in the evaluation, development, protection, management and commercialisation of IP. TTOs may provide services including IP assessment, market analysis, IP protection, licensing support, business development, investment readiness, commercial partnership development and spin-out support.

The UHB shall retain overall responsibility and accountability for decisions concerning the ownership, protection, licensing, assignment, commercialisation and disposal of IP where a TTO is engaged.

Ownership of IP generated by the UHB's employees shall remain vested in the UHB unless otherwise approved in accordance with the UHB's Scheme of Delegation and recorded in a written agreement. The appointment of a TTO shall not, of itself, confer any ownership rights in the UHB's IP.

Any agreement with a TTO shall clearly distinguish between Background IP and Foreground IP and shall define the ownership, use, licensing and exploitation rights applicable to each category.

NHS Wales organisations may utilise TTOs through a range of models, including:

- Collaboration with university-based TTOs and business accelerators;
- Engagement of private-sector TTO providers;
- Shared NHS Wales technology transfer arrangements; and
- In-house technology transfer expertise and capabilities.

Where a TTO is engaged, the UHB shall undertake appropriate due diligence on the proposed provider, including consideration of:

- Relevant expertise and experience;
- Governance arrangements;
- Conflicts of interest;
- Track record in commercialising healthcare, software, digital, data and research innovations;
- Financial standing;
- Value for money; and
- Compliance with applicable legal and regulatory requirements.

Where appropriate, the UHB shall consider alternative TTO providers and assess whether the proposed arrangement represents an appropriate balance of expertise, cost, value for money and anticipated benefit.

The UHB shall ensure that any partnership with a TTO reflects the principles of good governance, transparency, public accountability and the responsible stewardship of publicly funded assets.

Any actual, potential or perceived conflict of interest involving a TTO, its employees, advisers, inventors, investors or commercial partners shall be declared and managed in accordance with the UHB's Conflicts of Interest arrangements and any applicable governance requirements.

No assignment of IP, grant of an exclusive licence, equity participation arrangement, spin-out transaction, revenue-sharing arrangement or other material commercial transaction recommended by a TTO shall be implemented without approval in accordance with the UHB's Scheme of Delegation, Standing Financial Instructions and applicable governance requirements.

In determining whether to pursue a commercialisation opportunity through a TTO, the UHB shall have regard to:

- Patient and public benefit;
- Service improvement opportunities;

- Value for money;
- Affordability and resource implications;
- The responsible stewardship of publicly funded assets;
- Strategic alignment with the UHB's and NHS Wales objectives; and
- The likelihood of successful development and adoption of the innovation.

Where practicable, commercialisation arrangements shall preserve the ability of the UHB and other NHS Wales organisations to use relevant IP for healthcare, education, research and other public service purposes. Exclusive rights shall only be granted where they are necessary to support the proposed commercialisation strategy and have been approved through the appropriate governance arrangements.

Particular consideration shall be given to arrangements involving software, source code, algorithms, artificial intelligence systems, machine learning models, datasets, database rights, digital platforms and other digital assets to ensure that ownership, licensing, support, maintenance, information governance, cyber security and future development rights are clearly documented and appropriately protected.

All agreements with TTOs shall be documented in writing and shall contain appropriate provisions relating to:

- IP ownership and management;
- Confidentiality;
- Information governance;
- Data protection compliance;
- Freedom of information obligations, where applicable;
- Performance monitoring and reporting;
- Audit and assurance rights;
- Financial arrangements and remuneration;
- Termination and exit management;
- Handover of records and documentation;
- Return or destruction of confidential information; and
- Continuity of IP management following termination of the arrangement.

The UHB shall ensure that any fees, commissions or revenue-sharing arrangements payable to a TTO are proportionate, represent value for money and are appropriately documented and approved through the relevant governance processes.

The UHB shall make available appropriate training and awareness materials relating to IP and commercialisation for relevant staff and shall ensure that any

TTO arrangements align with the principles set out within this Policy and any associated Welsh Government guidance.

TTOs act in an advisory, support and delivery capacity and shall not exercise decision-making authority on behalf of the UHB unless expressly authorised in writing in accordance with the UHB's governance arrangements.

Further information regarding the use of TTOs and Technology Transfer Capabilities can be found in the Welsh Health Circular 2026 (004) NHS Wales Intellectual Property Guidance.

Relationship with Section 6 - PRINCIPLES FOR THE MANAGEMENT, DEVELOPMENT AND COMMERCIALISATION OF INTELLECTUAL PROPERTY

Specialist support may be utilised in relation to any of the development and exploitation routes identified in Section 6.

11 TRAINING

It is not envisaged that any formal training will be required as a result of the development of this policy. However, whilst training is not formally required the provision of training to foster a culture of innovation and staff engagement may be orchestrated through the R&D and Innovation teams to raise awareness of and ensure adherence to the policy provisions. The UK Government Intellectual Property Office offers online training and guidance www.ipo.gov.uk. Similarly, the World Intellectual Property Organization (WIPO) has an online training academy with a range of resources www.wipo.int. Many UK Universities also offer accessible online training and support materials.

12 IMPLEMENTATION AND COMPLIANCE

This policy reflects existing practice and therefore can be implemented immediately. Implementation and monitoring of this policy to provide necessary assurance to the UHB will be the responsibility of the Executive Medical Director supported by the R&D and Innovation teams.

The UHB wants to encourage staff to innovate and to benefit the UHB from IPR that is generated through the multiple activities of the UHB. The Assistant Medical Director of Clinical Innovation, alongside the R&D and Innovation teams, will work with innovators to seek out appropriate routes for application of IPR and assist in protection where appropriate.

If an employee fails to comply with this policy, the matter may be dealt with in accordance with the UHB Disciplinary Policy. The action taken will depend on the individual circumstances and will be in accordance with the appropriate workforce and organisational development policies.

13 EQUALITY STATEMENT

All public bodies have a statutory public sector duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies, services and functions impact on equality.

The UHB is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff, patients and others reflects their individual needs and does not discriminate, harass or victimise individuals or groups. These principles run throughout our work and are reflected in our core values, our staff employment policies, our service standards and our Strategic Equality Plan and Equality Objectives. The responsibility for implementing the Plan and Objectives falls to all employees and UHB Board members, volunteers, agents or contractors delivering services or undertaking work on behalf of the UHB. They are expected to deliver services and provide care in a manner which respects the individuality of each service user and their carers and treat users of UHB services and their carers fairly and members of the workforce with dignity and respect, regardless of gender, maternity and pregnancy, carer status, marriage or civil partnership issues, race, disability, sexual orientation, Welsh language, religion or belief, transgender and age. This obligation also includes issues to do with human rights.

13.1 Equality Impact Assessment

In order to meet these requirements, an Equality Impact Assessment toolkit is used to assess all UHB policies, services and functions procedures. Each staff member seeking to undertake a project will have the responsibility to consider the equality considerations for them as part of the business plan. The responsibility for undertaking any necessary Equality Impact Assessment will lie with the IPR developer and compliance will be monitored by the Assistant Director of Innovation, Assistant Medical Director of Clinical Innovation and R&D Director, as appropriate.

14 MONITORING AND REPORTING

The University Health Board shall monitor the effectiveness of this Policy through such measures as may be appropriate, including:

- Disclosures received;
- Patents and other registered rights obtained;

- Licences granted;
- Assignments completed;
- Collaborative agreements executed;
- Spin-out companies established;
- Commercial income generated;
- Innovations disseminated across NHS Wales;
- Service improvement outcomes achieved;
- Patient benefit outcomes identified; and
- The management and utilisation of artificial intelligence-enabled innovations and digital assets.

Formal review and reporting for assurance purposes will be through the Finance and Performance Committee.

15 DISTRIBUTION

This Policy will be available via the UHB Intranet and Internet Sites. Where staff do not have access to these resources the line manager must ensure that they are aware of the contents where appropriate.

16 REVIEW

The Policy will be reviewed to reflect any changes in guidance or legislation. As a minimum it will be reviewed 3 years after the date of approval.

APPENDIX A

Case Studies – Employee Ownership and Invention

Introduction

Under UK law, inventions made by employees who are employed to invent are owned by their employer. This is provided by statute (Patents Act 1977) which overrides contract law and specifically any terms in contracts of employment. In the UK, contract law is therefore generally only relevant in determining ownership of inventions made by inventors who are not employed in an inventive/creative capacity or outside of employment.

UK Law Relating to Employee Inventions – Section 39 UKPA77

In summary, an invention by default belongs to the inventor. However, in the case of employment, an invention made by an employee belongs to his employer **(1)**, if:

(1a) it was made in the course of his/her normal duties, or in the course of additional specifically assigned duties, **and** an invention might be reasonably expected to arise from them, or

(1b) it was made in the course of the employee's duties and implicit in these duties is a special obligation to further the interests of the employer.

Any other invention belongs to the employee **(2)**.

Notably, duties is not specifically defined and is often regarded as a role of employment rather than specific tasks that he or she may undertake as part of that employment. As a result, typically duties are stipulated in contracts of employment, and unless careful consideration of same is given, these are often by default quite vague and broadly defined.

To exemplify how this statutory provision may be applied, please consider the following theoretical case scenarios and how ownership may be determined in such cases.

Case Study 1: Dr X, Clinical Oncologist and Researcher

Dr X is a medical oncologist involved in assessment and treatment of certain types of cancer in the oncology department.

Normal Duties: Dr X is primarily employed to clinically assess and directly treat certain cancer subtypes in the oncology department. She also undertakes

research including cancer clinical trials, the development of new drugs and studies about the fundamental mechanisms of specific cancer subgroups.

Assigned Duties: No specific contracted duties.

Invention: Through undertaking a clinical trial, in collaboration with other health and academic institutes, Dr X has elucidated certain markers in urine samples that can be used as early diagnostic markers indicative of certain forms of renal cancers. Many of the clinical samples utilised in the trial were provided by Dr X with clinical records pertaining to same (including patient outcome, treatment path and survival).

Ownership: Dr X as part of her employment undertakes research into the clinical treatment of cancer and is regularly involved in, and undertakes, clinical trials into new treatments and therapeutics. As part of a collaboration an improved diagnostic test for the determination of cancer has been devised, a significant part of which has arisen from data generated from patient records forming part of his day-to-day tasks. Although her contract of employment is not specifically drawn towards this particular aspect of research, the invention has arisen as a consequence of same.

The invention thus resides with Dr X's employer and possibly the other health and academic institutes.

Case Study 2: Mr Y, Consultant Wound Care Specialist and Surgeon

Mr Y is a wound care specialist and surgeon with extensive experience in the sector.

Normal Duties: Mr Y has experience in reconstructive foot and ankle surgery, orthopaedic/general trauma, paediatric orthopaedics, diabetic limb salvage, and wound care. He is primarily employed to clinically assess all cases of wound care and treatment thereof including use of advanced treatment techniques such as wound vacs, skin substitutes and use of new ultrasonic debridement techniques as part of conventional treatment plans. His contract does not stipulate limits upon techniques to be employed or the development of alternative methods, but he is also employed to contribute to treatment pathways in this clinical area at the hospital.

Assigned Duties: No specific contracted duties.

Invention: Mr Y has determined that during the course of treating certain chronic wounds a particular dose of a specific and already known wound therapeutic has unexpected and preferential wound healing effects, far superior to that already experienced during conventional clinical treatment. Further, it has been determined that treatment is most effective during a certain clinical wound 'time-window'. The proposed invention is therefore use of a specific dosage regimen when using a known therapeutic for treating of wounds.

Ownership: Mr Y is not employed to invent or research, although he does so as part of his personal career progression. However, he is employed as a wound care specialist with a view to undertaking and devising treatment plans for patients, including performing treatment using existing or new treatment options.

Although not employed to innovate *per se,* the invention has arisen as a consequence of his regular day to day tasks, inherent problems faced when undertaking same and devising a solution that can be used as an alternative.

The invention thus resides with the employer.

Case Study 3: Mrs Z, Clinical Nurse Specialist

Mrs Z is a nurse currently employed in the department of Geriatric Medicine.

Normal Duties: Mrs Z provides clinical leadership and education for the Staff Nurses working in her department, and has specialist skills and knowledge upon which ward nurses can draw. Her role is to act with other nurses to advance nursing practices, improve outcomes, and provide clinical expertise to effect system-wide changes to improve programs of care. She has a role in directing clinical practice including expertise in advanced assessment, implementing nursing care, and evaluating outcomes. Her research involves interpreting and using research, evaluating practice, and collaborating in research.

Assigned Duties: No specific contracted duties.

Invention: Mrs Z, a keen gardener in her spare time, has devised a new and improved water butt that can be implemented into existing household water drainage systems. The system comprises a unique setup that allows retention of water flow from downpipes for use in the garden but importantly does not lead to reduced flow during heavy rainfall that can lead to overflow and flooding as with existing systems.

Ownership: Mrs Z is employed in the clinical sector. The proposed invention clearly is separate from her employment and normal course of duties and has no relevance or significance thereto. Devising the invention has arisen as a consequence of personal interest in a sector outside and separate from her employment.

The invention resides with the individual.

Summary

An employee who has developed an invention during the execution of duties pertaining to his/her employment contract i.e. usually, but not exclusively, during his/her working time within the institution/work environment using knowledge employed during his/her working day will belong to the employer.

To avoid confusion and possible disputes, employers often specify ownership of IP in employment contracts. However, in many circumstances, the employee's duties can be referred to quite vaguely, and so it is prudent to consider carefully an employee's duties when reviewing and agreeing contracts of employment.

Regardless, depending on the merits of each case, the employee may have a right to equitable remuneration in accordance with legislative provisions or the employment contract. The Patents Act 1977 provides a statutory regime whereby an employee may become entitled to financial reward, or compensation, where the employer has obtained outstanding benefit from a patented invention made by an employee. The relative amount of remuneration will vary from case by case, and will ultimately depend upon the success of the invention (having regard to the size and nature of the employer's undertaking) and the extent of the contribution made by the employee to the patent.

In any case, the employee will always retain the right to be mentioned as the inventor, unless he/she expressly renounces this right.

APPENDIX B

Innovative Ideas Disclosure Form

The Innovative Ideas Disclosure Form is used by staff to provide initial information to the Innovation Team to enable appropriate support and guidance to be given. The form and follow-up dialogue should be completed before sharing of ideas and concepts externally to ensure that any potential IPR is not compromised.

Copies of the Innovative Ideas Disclosure Form are available from the Innovation Team (cav.innovation@wales.nhs.uk) and is reproduced below for information.

Cardiff and Vale University Health Board

Innovative Ideas Disclosure Form

Purpose: Use this form to disclose a potentially innovative idea, product, process, service improvement, software solution, educational resource, or other intellectual property for assessment.

Until you have spoken directly with colleagues managing intellectual property on behalf of CAVUHB it is imperative that you do not communicate, publish or share your creation with others (for example, in the form of verbal discussions, posters and presentations at meetings) and especially not with parties outside of CAVUHB.

NOTE: ANY PUBLIC DISCLOSURE, PRIOR TO FILING, WILL IMMEDIATELY NEGATE THE RIGHT TO PATENT ANY INVENTION.

Return the completed electronic form to cav.innovation@wales.nhs.uk

Name	
Role/Job Title	
Directorate/Department	
Status of Employment [e.g. employee, contractor, secondee, student]	
Collaborating Individuals or Organisations	
Project / Innovation Title	

Idea Summary

Problem or Need Being Addressed

Potential Benefits to Patients / Health Service

Novelty and What Makes the Idea Different

Current Stage of Development

Preliminary Patent / Prior Art Search Results (including Espacenet searches for patents; Espacenet – patent search)

Any Other Relevant Information

☐	Supporting drawings attached
☐	Schematics attached
☐	Technical information attached
☐	Additional documents attached

Applicant Signature	Date

For Cardiff and Vale UHB IP Management Team Use Only

Reference number:

Comments and Actions:

APPENDIX C

Intellectual Property Protection

This appendix includes a very brief overview on some aspects of IP protection. For more detail please consult the Intellectual Property Office website "types of IP" section www.ipo.gov.uk/types.htm. This information is provided for guidance purposes only and is not intended to constitute a definitive or complete statement of the law on IP, nor is any part of it intended to constitute legal advice for any specific situation.

Goodwill

Reputation associated with an organisation or its value beyond net assets - commonly connected to its brand.

Know-how

“Know how” rights arise automatically and do not require registration. Know-how (also known as a "trade secret") is any information that is not in the public domain which has an assumed value. Know-how is often the most valuable of all IP assets and rights arise automatically with no need for registration. For example, it can be the knowledge about how to perform a procedure or to create a product or process. Know-how can be identified and protected by a Non-Disclosure Agreement (NDA) agreement (also known as Confidential Disclosure Agreements, CDA). When working with other parties, NDAs can be reciprocal agreements whereby the boundaries of confidential information that is disclosed and received is identified and obligations on both receiving and disclosing parties are detailed. A template NDA and advice may be obtained from the UHB Innovation and R&D teams. Know-how and confidential information are not capable of assignment as property rights but a formal information transfer coupled with a non-use and secrecy agreement can have the same effect. They persist indefinitely, as long as they remain covered by the terms of an NDA.

Copyright

Copyright rights arise automatically and do not require registration. Copyright covers a wide range of works including written and graphical information such as leaflets, articles, assessment tools, training packs, databases, computer software, “Apps” and films/videos, drawings and the 2-D representation of 3-D structures. Copyright is an automatic unregistered right that subsists if the work is "original". The requirements for originality are low. Therefore, it is best to assume that copyright will subsist in all written, graphic or photographic works generated by staff.

It is advisable to attach a statement to any works such as: Copyright (NAME OF ORGANISATION) Date XX. All rights reserved. Not to be reproduced in whole or in part without the permission of the copyright owner. However, you may decide to designate certain areas of activity for which permission does not have to be obtained.

For example, "not for-profit organisations such as NHS Wales Health Boards and Trusts, may reproduce this work solely for the purposes of teaching or further non-commercial research. In all other circumstances the permission of the UHB must be obtained".

Ownership

IP generated by an employee in the normal course of duties belongs legally to the employer and remains with the employer after the employee has left. The employer may decide to waive these rights at their discretion.

Patents

Patents need to be registered to attract protection. Patents can be used to protect "technical" inventions that are new and have a utility. The vast majority of ideas will have potential utility. In Europe and the majority of countries in the world "new" means that all of the features of the invention must not have been made available to the public in a single disclosure anywhere in the world prior to the patent filing date. A public disclosure can be written, verbal or by any other means (e.g. journals, internet, meetings, posters, etc) and could merely be the result of a conversation between friends. To qualify as a patentable invention the idea must also not be obvious. The assessment of what is obvious is a complex area of patent law and in the first instance staff are advised against concerning themselves with this criterion. In the UK, some inventions are specifically excluded from patenting where those inventions consist entirely of methods of treatment by surgery or therapy or diagnostic methods. However, these inventions are patentable in other countries, notably the USA.

Excluded inventions are also a complex area of patent law and staff are advised that if they think they have an invention which lies in an excluded category to please consult the R&D and Innovation teams in the first instance. However, it is best not to assume an invention is excluded in the first instance.

Design Rights

Design rights arise automatically and do not require registration. Design Rights protect against the copying of the shape or configuration of an article. Design Rights may exist in addition to other forms of protection offered by patents or copyright.

The "Design Right"

The "unregistered" Design Right as it is known, similar to copyright, is an automatic right and can last up to fifteen years. It can protect the 3D features of an article, internal and external features, but there are a number of exclusions for example where the article is dependent on another article the so-called “must-fit, must match" exclusion. A surgical instrument could be protected by this right. However, unregistered design rights are generally considered to be weak IP rights and often stronger rights such as patents are sought, at least to improve levels of protection. Given the particular requirement of this “niche” aspect of IP law it is best in the first instance not to assume that the design right will protect a given article.

Registered Design Rights

Both UK and European law provide for registered design rights which last up to 25 years. Registration is required to attract protection. Registered design rights protect the appearance of a product, for example its shape, colour or texture of materials. For example, a new design of surgical gown or a patient's pillow could be the subject of a registered design right.

Trademarks

A trademark is a sign or symbol that is used to distinguish a product or service of one undertaking (e.g. a company or organisation, such as an NHS organisation) from another undertaking. Trademarks need to be registered to attract protection. Trademarks can protect words, logos, shapes, colours and even smells (e.g. the name “Coca Cola” and also the shape of the Coca Cola bottle are registered trademarks). Trademarks are the IP right that protect brands. They can last forever, providing renewal fees are paid.

Database right

A database means a collection of independent works, data or other materials which are arranged in a systematic or methodical way and are individually accessible by electronic or other means. There are two types of IP protection for databases: database right and copyright. Both are automatic, unregistered rights that allow the owner to control certain uses of their databases.

Copyright protects the selection or arrangement of material in a database where this is original (i.e. creative). Database right protects the contents of a database. A database does not have to be original for it to qualify for database right, but there needs to have been a substantial investment in obtaining, verifying or presenting the contents of the database.

Database right is based on the European Community Directive 96/9 on the legal protection of databases. This was implemented in the UK by the Copyright and

Rights in Databases Regulations 1997, which remain in force as 'retained EU law' with amendments following the UK's departure from the EU. The maker of a database must have a connection with the UK (or the European Economic Area if the right arose before 31 December 2020). Databases created from 2021 onwards are only protected under UK law.

Database right lasts for 15 years from the end of the calendar year in which the making of the database was completed. Any substantial change to the contents of a database which can be considered to be a substantial new investment qualifies the database resulting from that investment for its own term of protection.

Report Title: *(needs to match agenda)*	Monthly Monitoring Return – Month 6		Agenda Item No:		4.1 a
Meeting:	Finance and Performance Committee	Public	x	Meeting Date:	18th November 2026
		Private			
Lead Executive Title:	Executive Director of Finance				
Report Author/s Title:	Deputy Director of Finance				

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

ADVISE *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

ASSURE *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

WHC (2026) 022 - 2026/27 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, Table A2 and Tables C to C3), to provide the Committee with transparency on the submission made to the Welsh Government.

A copy of the September 2026/27 MMRs is attached.

Board/Committee Response Required *(please select only one)*

To confirm the action Members are being asked to take considering the AAA Framework

Assurance		**Approval**		**Information/Noting**	x

Recommendations

Recommendations should be clear, actionable, and aligned to the AAA summary above.

NOTE the extracts from the UHBs Monthly Financial Monitoring Returns.

Governance Route *(please list all other Committee/Groups this report has been to)*

***Where** it's been:*	
***When** it went:*	
***What** decision was made:*	*e.g. Recommended to Board for approval*

Main Report

Background & Current Situation

The extracts from the UHBs Monthly Financial Monitoring Return are provided for information and assurance.

Appendices: *(List any appendices that will accompany this report).*
4.1b & 4.1c
Strategic Alignment – Shaping Our Future Wellbeing: *Please place an "X" against the strategic objective(s) this paper supports – Click the below tiles for further information.*

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

Impact Assessment *Please ensure each section is completed. (If "Yes" is selected, complete the detail. If "No", please write "Not applicable".)*
Risk: No
Not applicable
Safety: No
Not applicable
Financial: Yes
The financial position reported by the UHB to Welsh Government through the Monthly Monitoring Return is consistent with the financial position presented to the Finance Committee.
Workforce: No
Not applicable
Legal: No
Not applicable
Reputational: No
Not applicable
Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*
Not applicable
Equality & Health: No
Not applicable
Decarbonisation: No
Not applicable
Welsh Language: No
• *Not applicable*

MONTHLY MONITORING RETURNS (MMR) NARRATIVE

Cardiff and Vale University Health Board Financial Position for the Period Ending 30th September 2026



CONTENTS

1. **INTRODUCTION**
2. **MOVEMENT OF OPENING FINANCIAL PLAN TO FORECAST OUTTURN AND UNDERLYING POSITION (TABLE A & A1)**
3. **OVERVIEW OF KEY RISKS & OPPORTUNITIES (TABLE A2)**
4. **ACTUAL YEAR TO DATE (TABLE B AND B2)**
5. **SOCNE / SOCNI MOVEMENT (TABLE B1)**
6. **MOVEMENTS ON THE OPENING PLAN (TABLE B2)**
7. **PAY & AGENCY (TABLE B3)**
8. **SAVINGS PROGRAMME 2026-27 (TABLE C, C1, C2, C3 & C4)**
9. **INCOME/EXPENDITURE ASSUMPTIONS (TABLE D)**
10. **INCOME ASSUMPTIONS 2026/27 (TABLE E)**
11. **STATEMENT OF FINANCIAL POSITION (TABLE F)**
12. **CASHFLOW FORECAST (TABLE G)**
13. **PUBLIC SECTOR PAYMENT PERFORMANCE (TABLE H)**
14. **CAPITAL RESOURCE LIMIT, IN YEAR SCHEMES & DISPOSALS (TABLES I, J, K, P)**
15. **AGED WELSH NHS DEBTORS (TABLE L)**
16. **GMS (TABLE M)**
17. **DENTAL (TABLE N)**
18. **RINGFENCED ALLOCATIONS (TABLE O)**
19. **OTHER ISSUES**
20. **CONCLUSION**

1. INTRODUCTION

Following consideration by the UHB Board, a financial plan, which included a forecast deficit of £86.5m was submitted to the Welsh Government at the end of March 2026.

The submitted plan recognises the combined £5.4m recurrent savings shortfall and £7.1m recurrent operational pressures totalling £12.5m that arose during 2025/26, resulting in a brought forward underlying deficit of £68.8m.

Additional material recurrent operational pressures recognised within the initial 2026/27 plan include:

- £2.3m – Band 2-3 HCSW Implementation
- £2.1m – Increase in Employers National Insurance
- £0.9m – Mental Health Out of Area patients
- £0.8m – GP OOHs Contract
- £0.7m – Common Ailment Scheme
- £0.6m – Midwifery Streamliners

Any recurrent operational benefits delivered during the year are either reflected within the savings plan or offset against other recurrent operational pressures in arriving at the brought-forward underlying deficit.

The Health Board's submitted financial plan for 2026/27 remains unchanged at a deficit of £86.5m, in accordance with Welsh Government's reporting expectations.

At Month 6, the Health Board is reporting a year-to-date deficit of £46.4m, representing an adverse variance of £3.1m against the original profiled financial plan. Against the revised forecast deficit, which reflects the year-to-date benefit arising from the revised Welsh Risk Pool contribution, the adverse variance is £7.7m. This comprises a £10.3m shortfall against planned savings delivery, partially offset by a £(2.6)m operational surplus.

The forecast outturn for 2026/27 is a deficit of £77.4m, representing a £9.2m improvement against the submitted financial plan following confirmation of the reduction in the Health Board's Welsh Risk Pool contribution.

The forecast remains dependent on the delivery of further financial mitigations, with material risks continuing in relation to the savings programme and the recurrent financial position. The Welsh Risk Pool adjustment has been assumed to provide a recurrent benefit to the underlying position.

A summary of the annual plan submitted is provided in Table 1.

Table 1: 2026/27 Submitted Plan

Planning Assumptions	(£m)
Brought Forward Underlying Deficit	68.8
2026/27 Demand/Cost Growth/Improvement	54.7
2026/27 Increase in Contribution to Welsh Risk Pool	21.5
Deficit	**144.9**
Additional Allocations	(15.9)
Savings Plans	(42.5)
Initial Planned Deficit	**86.5**
Reduction to 2026/27 Contribution to Welsh Risk Pool confirmed Month 6	(9.2)
Revised Forecast Deficit £m	**77.4**

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 £46.4m, which is £7.7m over the revised forecast deficit.

2. MOVEMENT OF OPENING FINANCIAL PLAN TO FORECAST OUTTURN and UNDERLYING POSITION (TABLE A & A1)

Table A sets out the submitted financial plan and latest position at month 6 for which the following should be noted:

- Line 12 reconciles to the Health Board's £86.5m original planned deficit profiled flat.
- The UHB's initial £42.5m 2026/27 savings target is reported on lines 6,7 & 11.
- Assumed LTA inflation of £1.9m (1.11%) to the UHB from other Health Boards (line 4).
- The Health Board is reporting a year-to-date overspend of £46.4 million, representing an adverse variance of £7.7 million against the revised forecast deficit.
- The deterioration is driven by a £10.3m savings gap, £(8.0)m unplanned spend reductions and £5.4m unplanned cost pressures. Further detail around the unplanned movements is provided in section 4.

Following the Welsh Government arbitration ruling, the UHB has assumed a 2% reduction in the 2026/27 JCC LTA value, resulting in an estimated provider deficit of £7.1m and commissioner benefit of £2.0m, giving a net adverse financial impact of £5.1m.

To comply with Welsh Government's expectation that the original planned deficit remains at £86.5m, the financial plan includes an additional £5.1m savings requirement. This increases delivery risk.

For clarity, progress is being monitored separately against the UHB's Core savings target (£42.5m) and JCC savings target (£5.1m) to ensure transparent reporting of performance against each programme.

The Health Board acknowledges Welsh Government's feedback and has strengthened its focus on improving delivery of the savings programme. At Month 6, work is continuing through established financial recovery and accountability arrangements to enhance savings delivery, identify additional opportunities, and reduce reliance on unidentified mitigations. This is being supported through Executive-led challenge and review processes and overseen through the Board's established governance framework

In addition, the UHB has engaged external consultants to support and drive the internal turnaround work already underway. The support is expected to provide pace and assurance regarding the delivery of the planned 2026/27 deficit position.

Further updates will be provided as this work progresses and proposed actions are agreed through the appropriate governance arrangements.

The identification and delivery of the £42.5m core recurrent savings target and the additional £5.1m JCC savings target is key to delivery of the planned in year and underlying position.

The underlying deficit for 2027/28 is currently projected at £77.4million. This assessment assumes full recurrent delivery of the original 2026/27 Financial Plan and excludes any ongoing impact from current non-recurrent cost pressures or temporary expenditure reductions.

The projected underlying deficit also assumes that the reduction in the Health Board's planned contribution to the Welsh Risk Pool in 2026/27 can at this stage, be regarded as recurrent.

A reconciliation between the year to date deficit of £7.7m reported by the UHB to the YTD and Year End Forecast Deficit reported on Line 35 of Table A is shown on the table 2 below

Table 2: Reconciliation of Table A Deficit to UHB in year variance from Revised Forecast Deficit

Line	Planning Assumptions	YTD £'000s	In Year Effect £'000s
12	Opening IMTP / Annual Operating Plan	-43,274	-86,547
35	Forecast Outturn (- Deficit / + Surplus)	-46,356	-77,369
	Difference Table A Opening Plan & Foreacst Outturn	-3,082	9,178
19	Additional In Year & Movement in Planned Welsh Government Funding & Other Income (Positive Value - additional) Reduction to Welsh Risk Pool Contribution	-4,589	-9,178
	Reported Variance to Revised Forecast Deficit £'000s	-7,671	0

3. OVERVIEW OF KEY RISKS OPPORTUNITIES (TABLE A2)

Table A2 reflects the risks identified in the financial plan and these will continue to be reviewed on a monthly basis. The table outlines the following risks:

- The UHB is reporting a material shortfall of £15.5m against its core £42.5m savings target. When considering the forecast operational position, this is assumed to be managed on the basis 50% of the £20m red pipeline schemes will be converted to green delivery in year alongside continued operational underspend. The UHB is also reporting a £5.1m risk against the additional

savings requirement arising from the new £5.1m (2%) JCC efficiency target. Progress against the £5.1m JCC savings requirement will be monitored and reported separately to support transparency over delivery.

- The risk of £0.5m in respect of ePMA aligns with the contingency fund identified in the original Business Case. The UHB continues to pursue opportunities to de-risk the ePMA contingency in collaboration with Welsh Government & DHCW colleagues and anticipates further progress following the outcome of the review of DPIF funding commitments.

- The Health Board has assumed income/funding of £0.6m in relation to the new Resident Doctors contract.

- The financial impact of student streamliners recruitment continues to be reviewed and remains to be confirmed.

The first phase of the new Resident Doctors' Contract was implemented through payroll in August. Based on payroll data from the first month of implementation, the estimated cost of Phase 1 is £1.8m, which is materially higher than both the HEIW planning assumptions and the £0.6m of additional funding previously identified. These additional costs have been incorporated into the UHB's forecast outturn and are therefore excluded from the Risk Table.

In addition to the increased costs arising from the pay scale reforms, the UHB will be required to employ an additional 18 WTE Resident Doctors to ensure compliance with rota requirements. Furthermore, two further phases of contract reform are planned. As a result, the gross recurrent cost impact, before any additional funding is received, is estimated to increase to approximately £8.5m per annum, significantly exceeding the 2026/27 cost estimate. This projected cost is materially higher than the assumptions and associated funding levels previously modelled by HEIW.

The estimated implementation cost will continue to be refined as further payroll data becomes available, particularly in relation to overtime and enhancement payments, where the full financial impact has yet to be fully established.

The UHB is working to identify all risks that may crystallise during the year to allow mitigation or avoidance plans to be developed and implemented ahead of any associated costs.

4. ACTUAL YEAR TO DATE (TABLE B AND B2)

Table B and Table 2 below confirm the year-to-date deficit of £46.4m, consistent with the analysis set out in the annual operating plan (Table A).

The UHB's has a revised forecast deficit of £77.4m. At Month 6, the reported deficit is £7.7m adverse to the revised forecast deficit, primarily due to a forecast £20.6m

shortfall in the delivery of the combined core and additional JCC savings target of £47.6m. The UHB continues to work with budget holders to strengthen and accelerate delivery of savings schemes to support the delivery of the submitted plan. The overspend trajectory against plan improved further in Month 6, with the rate of deterioration continuing to slow compared to earlier months in the financial year. This improvement was primarily driven by a stronger commissioning position, with six twelfths of the projected £1.4m year-end underspend across JCC, LHBs and Velindre reflected in the reported position at Month 6. In addition, the Health Board improved savings delivery and a reduction in cost pressures during the month. While this represents positive progress, a significant delivery risk remains, particularly in relation to the achievement of the savings programme.

Table 3: Summary Financial Position for the period ended 30th September 2026

	Revised Forecast Deficit PTD (£m)	PTD (£m)	PTD Variance to Revised Forecast Deficit (£m)	Revised Forecast Deficit YTD (£m)	YTD (£m)	YTD Variance to Revised Forecast Deficit (£m)
Revised Plan	5.8	5.8	0.0	59.6	59.6	0.0
Quality Efficiency Improvement Plans - Savings	3.2	2.2	1.0	20.9	10.6	10.3
Operational Variance	0.0	0.4	0.4	0.0	2.6	2.6
Clinical/Service Board Variance	**2.6**	**3.2**	**0.6**	**38.7**	**46.4**	**7.7**

The Month 6 deficit of £46.4m comprised of the following:

- £38.7m revised forecast deficit (six twelfths of the £77.4m revised planning deficit)
- £10.3m CRP deficit
- (£2.6m) surplus operational variance against forecast deficit.

The operational surplus of (£2.6) is primarily driven by the following issues:

Unplanned Cost Pressures - £5.4m

- Medicine endoscopy insourcing - £1.1m
- Mental Health Out of Area Patients - £1.2m
- Specialist Medical Locum Usage (covering gaps due to restricted duties, rota gaps, interventional cardiologists) - £1.5m
- Specialist Private Patient Activity Reductions - £0.7m
- New Resident Doctors contract - £0.3m
- Vacancies across the Health Board - £0.3m (due to the positive/negative figure input rules for Table B2)
- Surgery High Wet AMD Out of Area Activity - £0.4m (due to the positive/negative figure input rules for Table B2 this corresponds to the unplanned cost reduction of the same value with a net zero impact overall)

Unplanned Cost Reductions - £(8.0)m

- Surgery High Wet AMD Out of Area Activity - £(0.4)m (due to positive/negative figure input rules for Table B2 this corresponds to the unplanned cost pressure of the same value with a net zero impact overall)
- Medicines Management – Variance against growth assessments in Prescribing/Community Pharmacy/Common Ailment Scheme/HIV/NICE HCD - £(1.4)m
- Vacancies across the Health Board - £(4.3)m
- Specialist Medical Locum usage mitigating actions - £(0.9)m
- LHB Expenditure Reduction & JCC Commissioner position - £(1.1)

Table 4: Summary of reasons for variance to Financial Plan including Forecast

Operational Pressure & Savings Shortfall	Variance YTD £m	Variance Forecast £m
Endoscopy Insourcing and Recruitment Outside of Plan	1.1	1.3
Mental Health Out of Area Placements	1.2	1.4
Specialist Medical Locum Usage	0.6	0.8
Specialist private patient activity reductions	0.7	1.4
Resident Doctors Contract	0.3	1.2
Programme Slippage (incl. Value)	0.0	(1.0)
Release of Deferred R&D Income	0.0	(0.5)
Procurement Opportunities	0.0	(0.9)
LHB Expenditure Reduction & JCC Commissioner	(1.1)	(1.9)
Medicines Management (Primary Care & NICE)	(1.4)	(2.8)
Pay Vacancies across the Health Board	(4.0)	(9.1)
Savings Shortfall	10.3	20.6
Sub-Total Surplus/Deficit	**7.7**	**10.5**

It is expected that all unplanned cost pressures arising in 2026/27 will have corresponding mitigations identified to deliver the revised £77.4m forecast deficit. Any continuation of unplanned cost pressures beyond March 2027 is not currently reflected as a deterioration in the underlying deficit position, on the basis that appropriate mitigating actions are expected to be identified. This remains an assumption and any recurrent pressures without identified mitigations would adversely affect the underlying position.

Executive-led turnaround meetings have been established with each Clinical Board and Service Board to support the delivery of both in-year target control totals and recurrent financial sustainability. These arrangements provide a structured forum for the identification and progression of mitigating actions, including the management of current and emerging operational pressures.

Whilst the 30 June 2026 milestone for achieving the planned Green/Amber assurance ratings was not fully achieved, the level of assurance has continued to improve. The Health Board is maintaining momentum in developing and refining schemes to further de-risk delivery of the 2026/27 Financial Plan.

5. SOCNE / SOCNI MOVEMENT (TABLE B1)

As part of routine review, the Health Board continues to review and refine the coding and forecasting of income and expenditure to ensure alignment with the latest expectations and reporting requirements, which may give rise to movements between categories; outside of these presentational changes, the key underlying movements are set out below.

Income

Following submission of the financial plan, a number of anticipated additional resource limit assumptions have been assumed as outlined in table B2. The key changes are attributable to depreciation and impairments, the Real Living Wage increase affecting Bands 2 and 3, and the Agenda for Change and Medical pay awards implemented in April and June 2026 respectively, as detailed in Table 5 below:

Table 5 – Movement in Resource Limit Assumptions following submission of the MDS as at 30th September 2026

Movement in Resource Limit Assumptions following submission of the MDS as at 30th September 2026	£m	£m
Total WG Agreed Revenue Resource Limit /Income as per allocation paper		1,474.776
Sub Total RRL Further Funding Assumptions not in allocation paper		43.544
Resource Limit Assumptions per MDS £'000s		1,518.320
Movement in Resource Limit Assumptions following submission of the MDS		
2026-27 AFC & Real Living Wage Pay Award	27.167	
Non Cash Depreciation & Impairments	(9.846)	
Planned Care Transformation Fund Optometry Community Pathways: Funding Extension for 2026 27	0.092	
Stengthening Community Nursing: Neighbourhood District Nursing (NDN) Development 2026 27	0.117	
Womens Health Hubs	0.200	
ESR & ESR Helpdesk	1.925	
All Wales Recruiment	0.016	
ESMCP Resources / CRS / MDVS / ARRP	0.046	
Consultant Allied Health Professional for Dementia	0.030	
Consultant Clinical Excellence Award / Consultant Impact Award	(0.421)	
DPIF - Approved Funding ePMA Disbursements	0.687	
DPIF - Appoved Funding EPS Go Live	0.060	
GMS Dispensing Doctors / PADMS & List Size Funding	0.271	
GP IM&T Refresh Programme	0.408	
Health Equity Wales Funding 2026 2027	0.033	
Immunisation Funding - Varicella	0.533	
MH Advocacy Funding	0.306	
Neurodivergence Improvement Programme	0.207	
NHS Wales 111 Digital Platform Transfer - JCC	0.179	
Short Breaks For Carers	0.172	
26-27 M&D Pay Award	9.038	
Climate Change Adaption Secondment	0.006	
Climate Focussed Spread and Scale Academy	0.026	
Digital Eyecare Programme	(0.174)	
DPIF Badgernet Neonatal EPR Programme	0.063	
Immunisation Programme Changes	0.090	
DPIF - Approve Funding EPMA Disbursements transferred to DHCW	(0.687)	
Direct Payments for CHC - Implementation and Funding	0.099	
Public Health LHBs in Prevention for Gambling Harms	0.041	
Guardian of Safe and Flexible Working	0.046	
All Wales Phamogenetics Lead Post	(0.096)	
2026-27 GMS Global Sum List size adjustment	(0.120)	
Project Manager Independent Review of Clinical Pharmacy Services	0.025	
Planned Care Recovery 2026-27: Funding Allocation Confirmation	16.354	
Resident Drs Contract additional HEIW TGS 2026 HB enhancements	(0.168)	
Pharmogemetics POCT MT TNR1 Neonate	0.088	
WELSH RISK POOL	9.178	
Movement in Resource Limit Assumptions following submission of the MDS		55.989
Total Resource Limit Assumptions Year to Date £m		**1,574.309**

Expenditure

The following table sets out the key expenditure movements from the prior month's MMR submission.

Expenditure Category	Narrative
Primary Care Contractor (excl. drugs, incl. NRL expenditure)	The forecast for Primary Care contractor expenditure has been reviewed to reflect the latest contract changes and associated growth assumptions. This includes recognition of £0.2m WGOS growth, and increased NCL expenditure of £1.5m (this does not represent a pressure to the health board).
Primary Care - Drugs & Appliances	No significant changes have been made to the Primary Care – Drugs & Appliances forecast this month but is continually reviewed as new data becomes available.
Provided Services – Pay	The Pay forecast does not include the anticipated impact of the recently communicated vacancy hold measures, which are currently reported within the savings programme as a Red-rated scheme and therefore reported through our gap on non-pay. Any further benefit will be reflected in the forecast once delivery is sufficiently assured. The winter capacity costs are now reported against pay (previously reported on non pay) following the latest bed plan.
Provider Services - Non Pay (excluding drugs & depreciation)	Increase in forecast is driven by the Planned Care allocation, further detail will be provided in the Planned Care Return.
Secondary Care – Drugs	The forecast has been updated following a review of growth assumptions against NICE High Cost Drugs (HCD). These assumptions will continue to be reviewed and refined as further data becomes available. Month 6 saw an increase in CAR-T drugs, Haem NICE and Porphyria NHSE.
Healthcare Services Provided by Other NHS Bodies	This includes movements linked to JCC-related expenditure and other LTA/commissioning updates.
Non Healthcare Services Provided by Other NHS Bodies	No additional comments
Continuing Care and Funded Nursing Care	Rephasing of expenditure.
Other Private & Voluntary Sector	The movement largely relates to reclassifications following the review of Clinical Board expenditure categorisation.

Losses, Special Payments and Irrecoverable Debts	No additional comments

6. MOVEMENTS ON THE OPENING PLAN (TABLE B2)

The plan values have been adjusted to reflect the Green and Amber savings schemes recognised at Month 1. Following discussion and review with Welsh Government colleagues, the revised values were agreed as part of the Month 3 submission but are included below for completeness.

The values were calculated as follows:

		MDS Savings Plan			Month 1 Savings Plan		
	MDS Plan	Green & Amber	Red & Gap	MDS Plan excl. Savings	Green & Amber	Red & Gap	Month 1 Plan
Primary Care Contractor (excluding drugs, including non resource limited expenditure)	205,188			205,188			205,188
Primary Care - Drugs & Appliances	109,788	1,198		110,986	1,195		109,791
Provided Services - Pay	1,035,510	1,214		1,036,724	1,634		1,035,090
Provider Services - Non Pay (excluding drugs & depreciation)	212,837	3,570	34,757	251,164	5,435	29,434	216,295
Secondary Care - Drugs	180,370	373		180,743	3,014		177,729
Healthcare Services Provided by Other NHS Bodies	303,265			303,265			303,265
Non Healthcare Services Provided by Other NHS Bodies	0			0			0
Continuing Care and Funded Nursing Care	127,904	1,359		129,263	1,359		127,904
Other Private & Voluntary Sector	15,457			15,457			15,457
Joint Financing and Other	0			0			0
Losses, Special Payments and Irrecoverable Debts	0			0			0
	2,190,318	**7,714**	**34,757**	**2,232,789**	**12,637**	**29,434**	**2,190,718**

In addition to the narrative below, a reconciliation for unplanned spend reductions and unplanned cost pressures has been provided in Annex 1.

Expenditure Category	Narrative
Primary Care Contractor (excl. drugs, incl. NRL expenditure)	Expenditure run rate has been amended to include the GMS uplift (virement against non-pay) as per actions following submitted plan. Additional spend associated with in year funding includes GMS Dispensing Doctors/PADMS & List Size funding (£0.2m) and GP IM&T Refresh Programme (£0.4m).
Primary Care - Drugs & Appliances	Growth assessments continue to be reviewed and refined as prescribing data becomes available. The latest forecast has been updated to reflect prescribing activity through July 2026 and has been adjusted accordingly alongside a revised assessment of NICE High Cost Drugs (HCD) expenditure.
Provided Services - Pay	£36.0m additional spend associated with in-year funding driven primarily by A4C uplift and M&D uplift. £(4.3)m unplanned spend reductions driven by temporary vacancies across the Health Board. The forecast assumes a full-year expenditure reduction of £(9.1)m arising from continued vacancy levels following recent recruitment. The recurrent impact is currently being assessed. £0.6m unplanned cost pressure to Month 6 associated with Specialist Services medical locum usage covering gaps due to restricted duties, rota gaps and interventional cardiologists. There are mitigating actions in place to reduce the forecast cost pressure. £0.2m forecast unplanned cost pressure from recruitment associated with Endoscopy (following cessation of insourcing arrangements). There is no recurrent pressure forecast as mitigations are expected to

	be identified and in place to avoid deterioration in the Health Board's underlying deficit. The start of the implementation of the new Resident Doctors contract has resulted in an unplanned cost pressure of £0.3m to Month 6 with a forecast £1.2m to the end of the year. The recurrent position is being assessed.
Provider Services - Non Pay (excluding drugs & depreciation)	£34.2m additional spend associated with various in-year funding/income, with £16m associated with Planned Care allocation. £1.1m Endoscopy insourcing cost pressure to Month 6 (recruitment to be in place from Q3 onwards) £0.7m pressure to Month 5 associated with Specialist Private Patient Activity reductions. The pressure is expected to continue at the current rate with a forecast of £1.4m. £5.4m planned mitigations to deliver the core savings target acknowledged within the submitted plan (less the forecast operational surplus. £5.1m unplanned mitigations to be finalised to manage the JCC 2% efficiencies target.
Secondary Care - Drugs	No additional comments
Healthcare Services Provided by Other NHS Bodies	Unplanned spend reductions of £1.1m due to LHB expenditure reduction and an updated JCC Commissioner position.
Non Healthcare Services Provided by Other NHS Bodies	No additional comments
Continuing Care and Funded Nursing Care	No additional comments.
Other Private & Voluntary Sector	£1.2m unplanned cost pressure to Month 6 associated with Mental Health Out of Area placements. The forecast has been updated to reflect a full-year adverse financial impact of £1.4m in 2026/27. This pressure has been escalated through the Health Board's turnaround meeting process, with actions identified and being progressed to mitigate the forecast impact.

7. PAY & AGENCY (TABLE B3)

The UHB has recorded average monthly agency costs of £0.3m for the year to date which compares to an average of £0.4m recorded in 2025/26.

The UHB recorded expenditure on administrative and clerical staff and Additional Clinical Services and Estates categories in September as follows:

- Administrative and Clerical - £0.014m – Specialist cover for Clinical Coding Vacancies.
- Estate and Ancillary- -£0.002m primarily relating to security & stores costs.
- The in-month credits reported against Medical & Dental, Additional Clinical services and Healthcare Scientists are due to a re-assessment of accrued expenditure.

8. SAVINGS PROGRAMME 2026-27 (TABLE C, C1, C2, C3 & C4)

Following the Welsh Government arbitration ruling in favour of the JCC, the UHB has assumed a 2% reduction in the value of the 2026/27 LTA. This is estimated to result in a provider deficit of approximately £7.1m and a commissioner benefit of approximately £2.0m, resulting in a net adverse financial impact of £5.1m for the UHB.

In line with Welsh Government's expectation that the UHB should not increase its original planned deficit of £86.5m, the financial plan incorporates an additional £5.1m savings requirement on the assumption that further efficiencies can be delivered beyond those included within the original planning assumptions. This increases the overall total savings target from £42.5m to £47.6m.

For clarity, the UHB is monitoring progress against the UHB's Core savings target (£42.5m) and JCC savings target (£5.1m) separately to ensure transparent reporting of performance against each programme.

The revised overall savings target represents a £5.1m increase from the initial planned savings target of £42.5m.

At Month 6, the UHB has identified £27.0m of Green and Amber-rated savings, representing 63.6% of the core £42.5m savings target and leaving a remaining shortfall of £15.5m. The value of identified Green and Amber savings has increased by £2.4m from the £24.6m reported at Month 5, reflecting continued progress in the development and assurance of savings schemes. The UHB has identified a further £20.4m of red schemes which bridge the gap to the core £42.5m savings target.

Work is ongoing with JCC to progress savings and efficiencies against the £5.1m JCC savings target.

A number of the schemes are non-recurrent in nature. The full-year recurrent value of identified schemes is £20.7m, resulting in a recurrent shortfall of £21.8m against the core savings target of £42.5m. In addition, no confirmed schemes have yet been identified to deliver the additional recurrent £5.1m JCC savings requirement.

Further work is therefore required to identify and implement recurrent savings schemes to close both the core and the additional JCC efficiency savings gap. The £77.4 million estimate of the underlying deficit assumes that further recurrent schemes will be identified and delivered to close the remaining funding gap; however, at this stage, the achievement of these schemes remains an assumption.

The Health Board recognises the requirement to progress Amber schemes to Green within three months of their inclusion on the tracker and is monitoring this accordingly.

The following 6 amber schemes have not been progressed to green status within the required 3 month period and their forecast outturn for 2026/27 have been revised to nil accordingly:

- 4 - CAWG&C001 - CHFW - Centralised Ward Stockholding
- 5 - CAWG&C002 - CYPFHS - Review of Stock Issued
- 8 - CYPFHS - CYPFHS - Respite (Glan Ely CHC)
- 13 - 4 - CDC benefit once performance levels have improved
- 55 - AM10 - Reduce staff sickness to target rate, improving availability and lowering temporary pay
- 137 SURG2627032 Private Patent Income

Forecast values will be re-instated if the schemes reach green status.

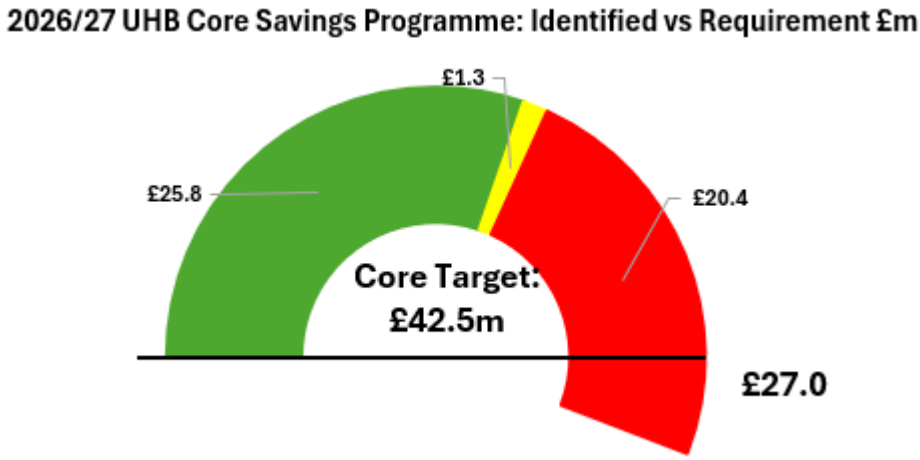
The in-year red schemes totalling £20.4m which are identified include additional measures agreed by the Executive Team, principally:

- a 380 WTE vacancy hold, based on retaining 50% of turnover arising between 1 August 2026 and 31 March 2027; and
- a 10% reduction in bank expenditure.
- a 30% agency reduction in line with the national target
- acute bed capacity reduction and remodelling

At Month 6, the UHB is reporting a risk of £5.1m in respect of Additional Required Mitigations yet to be finalised.

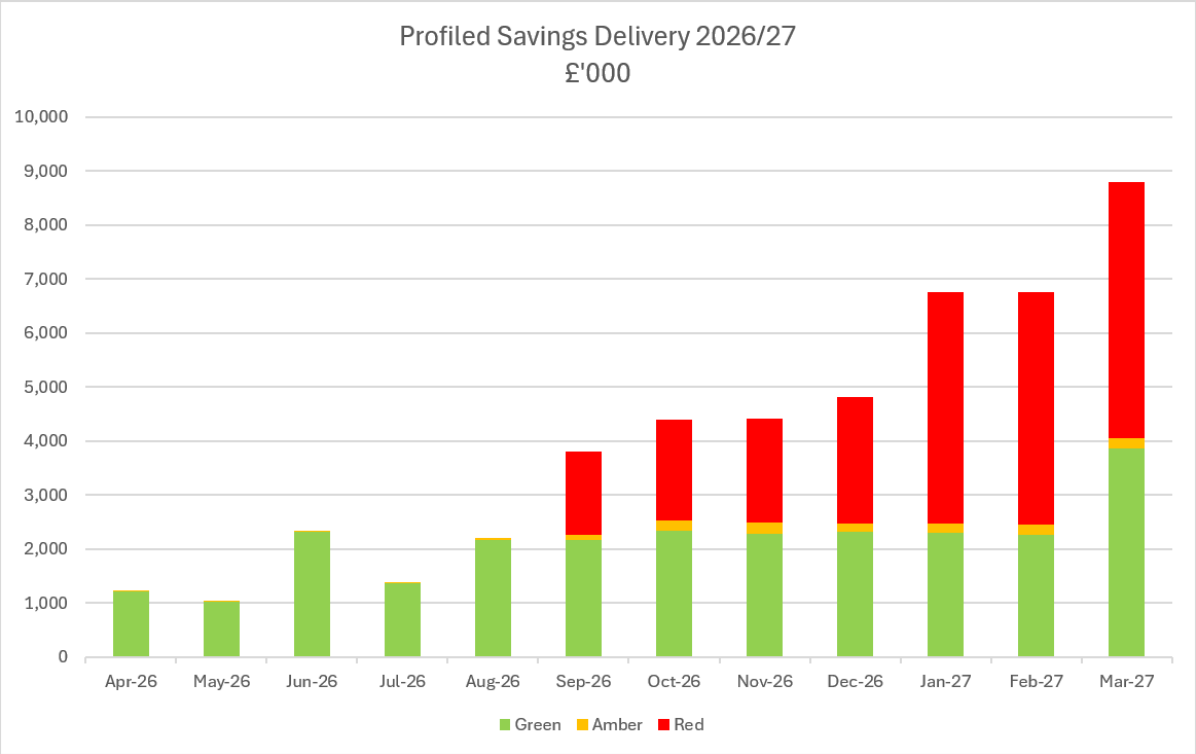
Graph 1 below outlines progress in the identification of Savings Schemes against the Health Board's core savings target.

Graph 1 – Progress in the Identification of Savings Schemes against the core savings target



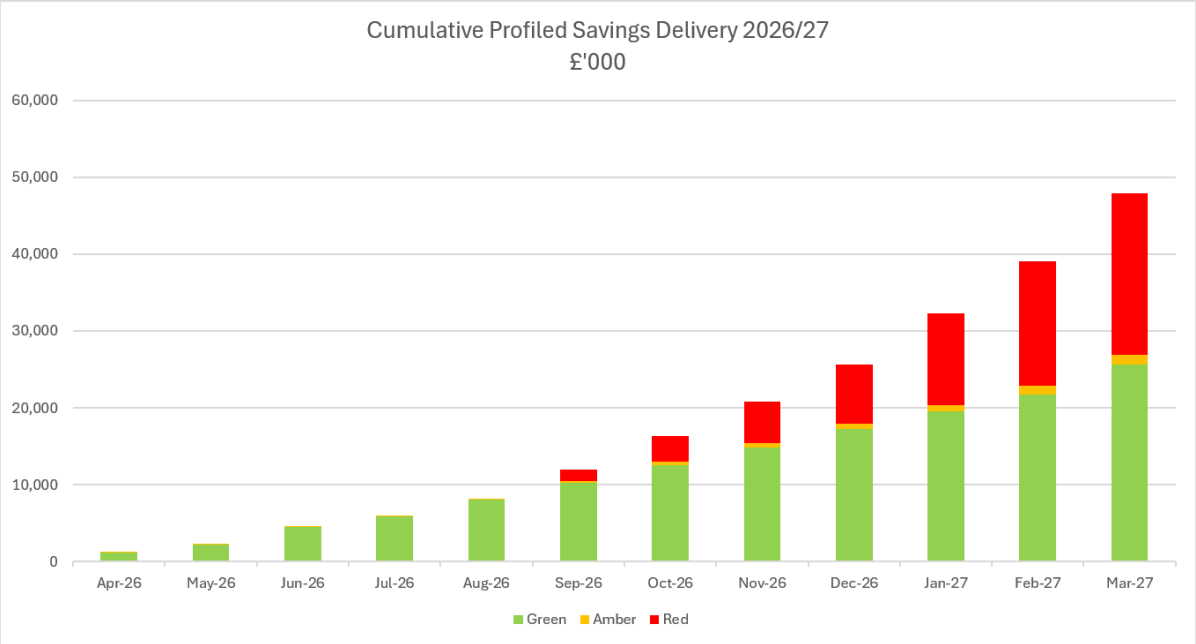
Graph 2 below provides a breakdown of the profiled savings delivery including red schemes against the core UHB savings target of £42.5m.

Graph 2 – Profiled Savings Delivery 2026/27



Graph 3 provides a breakdown of the cumulative profiled savings delivery including red schemes against the core UHB savings target of £42.5m.

Graph 3 – Cumulative Profiled Savings Delivery 2026/27



9. INCOME/EXPENDITURE ASSUMPTIONS (TABLE D)

NHS organisations are expected to have concluded discussions and signed contracts (Long Term Agreements and Service Level Agreements) between each other by 14th of May 2026.

The Health Board has completed and signed off all LTA documentation with partner organisations including the Joint Commissioning Committee (JCC) agreement.

The UHB has updated its income and expenditure assumptions in respect of JCC to align with the outcome of the arbitration decision.

10. INCOME ASSUMPTIONS 2026/27 (TABLE E)

Table E outlines the UHB's 2026/27 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 £0.2m recognised in previous financial years.

It is assumed that the costs which arise following the implementation of the new resident doctors contract will be partially funded in line with HEIW modelling.

The UHB's confirmed Revenue Resource Limit as of 30th September 2026, was £1,486.5m with a further £87.8m of assumed allocations as detailed at Table 6:

Table 6 – Unconfirmed in year Resource Limit Allocations anticipated on 30th September 2026

Unconfirmed Drawing and Resource Limit Allocations as of 30th September 2026	Resource Limit £'m
26-27 AFC Pay Award	26.6
26-27 AFC Pay Award Band 3 Compression	0.6
26-27 M&D Pay Award	8.9
26-27 M&D Pay Award CU Employed Consultants	0.2
A2A Sanctuary	0.5
All Wales International Recruitment	0.0
ATMPS (JCC)	1.9
Budvidal - HMP Prison Cardiff Costs	0.2
Consultant Clinical Excellence Award / Consultant Impact Award	0.8
Depreciation, Impairments And IFRS 16	36.8
Direct Payments for CHC - Implementation & Funding	0.0
EPMA Business Case Contingency	0.5
ESMCP Resources / CRS / MDVS / ARRP	0.1
ESR & ESR Helpdesk	1.9
GMS Disp Doctors / PADMS & List Sized Funding	0.3
GP IM&T Refresh Programme	1.6
Individual Placement & Support In Primary Care	0.3
Integration And Rebalancing Capital Fund (IRCF)	0.5
MH Advocacy Funding	0.3
Neurodivergence Improvement Programme	1.0
Planned Care Recovery 2026-27: Funding Allocation Confirmation	16.4
Planned Care Transformation Fund Optometry Community Pathways	0.1
Prevention And Early Years	0.8
Public Health LHBs in Prevention for Gambling Harms	0.0
Resident Drs Contract additional HEIW TGS 2026 HB enhancements	(0.2)
TSW Funding	0.2
Vertex (JCC)	5.2
VSM Pay Award	0.1
Welsh Risk Pool	(18.0)
Womens Health Hubs	0.2
Total Anticipated Funding £'000s	**87.8**

At this stage, it is assumed that the additional funding associated with the reformed Resident Doctors' pay scales, implemented in August, will be distributed via HEIW.

The Depreciation, Impairments and IFRS16 total has been updated to reflect the latest Non Cash return submitted 3rd August 2026. The difference between the IFRS16 revenue resource reduction figure of (£4.0m) and the IFRS16 revenue

drawing limit of (£5.0m) relates to the RISP contract – this has been included in the IFRS16 return submitted 3rd August to Zoe Ponting/Rifath Yaksambi.

11. STATEMENT OF FINANCIAL POSITION (TABLE F)

The Opening Balances at the beginning of April 2026 reflect the closing balances in the 2025/26 Final accounts.

The reduction in Property, plant & equipment is predominately due to capital purchases combined with the impact of monthly depreciation and impairment charges.

The carrying value of Trade and Other receivables has remained consistent with Month 5 reported figures.

The carrying value of Trade and Other Payables has remained consistent with Month 5 reported figures.

The carrying value of Provisions has remained consistent however the split between Current and Non-Current Liabilities reflects changes made to settlement dates.

The forecast balance sheet reflects the UHB's latest non-cash estimates and its anticipated capital funding.

12. CASHFLOW FORECAST (TABLE G)

The closing cash balance at the end of September was £3.3m.

In due course, the UHB expects to seek Finance Committee and Board approval to request £77.4m strategic cash support from Welsh Government to cover the cash shortfall arising from the forecast deficit.

Alongside the strategic cash support outlined above, the UHB estimates that the following working capital support will be required:

- Capital: £12.0m to support 2025/26 year-end capital creditors.
- Revenue: £6.5m to support 2025/26 Revenue Resource Limit adjustments that are not backed by cash, principally relating to Health and Social Care Worker recognition payments relating to 2025/26 which were actioned in the 2026/27 payroll.

The additional cash support required will continue to be reviewed as the year progresses.

13. 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 96.5%.

14. CAPITAL RESOURCE LIMIT, IN YEAR SCHEMES & DISPOSALS (TABLES I, J, K, P)

Of the UHB's approved Capital Resource Limit, 11% has been expended to date. All projects are currently forecasted to deliver in line with the CRL dated 6 October 2026, totalling £47.238m, with the exception of the ICRF scheme for the Park View Health and Wellbeing Hub.

A full scheme slippage review is currently being undertaken to be submitted to Welsh Government in line with the information request deadline.

Due to a one-month delay in signing the SCP contract for Park View, the UHB now anticipates expenditure of £5.7m against the original £7.6m forecast currently included within the CRL. The Health Board continues to engage with Welsh Government colleagues regarding the proposed £1.945m reduction in CRL funding for the Park View scheme. The risk rating for the scheme has been increased to medium to reflect the revised cashflow profile.

The £20k CAME funding requirement included within Table P represents the estimated increase in the current dilapidation provisions due to indexation, allocated across six properties.

15. AGED WELSH NHS DEBTORS (TABLE L)

On the 30th September 2026 there were 5 invoices raised by the UHB against other Welsh NHS organisations which were outstanding for more than 17 weeks. One invoice has subsequently been paid, the UHB is pursuing OO numbers from Aneurin Bevan for the other 4 invoices. There were 34 invoices which were outstanding for more than 11 weeks. Twelve of the invoices have now been paid, with the remaining invoices continuing to be actively pursued.

16. GMS (TABLE M)

The GMS Plan and forecast expenditure are outlined at Table M. The forecast expenditure is projected to exceed the Welsh Government Allocation.

17. DENTAL (TABLE N)

The Dental Plan and forecast expenditure are outlined in Table N. Forecast expenditure is projected to exceed the Welsh Government allocation.

With regard to the dental position, the UHB is currently reporting a £0.8 million benefit arising from contract hand-backs. The UHB would welcome clarification from Welsh Government as to whether the associated income shortfall (approximately £1.2 million) will be taken into account when determining any funding to be returned to Welsh Government, or whether the assessment will be based solely on the value of the contract hand-backs.

This clarification would assist the UHB in accurately reflecting the financial impact within its reported position.

18. RINGFENCED ALLOCATIONS (TABLE O)

Table O outlines the 2026/27 ring-fenced allocations and profiled expenditure. Forecast expenditure across all funding streams is in line with the agreed funding allocations and remains consistent with the approved funding levels.

Following confirmation of the Planned Care Recovery 2026/27 Funding Allocation in September, the UHB is finalising its plans for delivery. Progress against the agreed plan will continue to be monitored and reported through established governance and performance management arrangements.

19. 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.

20. CONCLUSION

The Health Board's submitted financial plan for 2026/27 remains unchanged at a deficit of £86.5m, in accordance with Welsh Government's reporting expectations.

At Month 6, the Health Board is reporting a year-to-date deficit of £46.4m, representing an adverse variance of £3.1m against the original profiled financial plan. Against the revised forecast deficit, which reflects the year-to-date benefit arising from the revised Welsh Risk Pool contribution, the adverse variance is £7.7m. This comprises a £10.3m shortfall against planned savings delivery, partially offset by a £(2.6)m operational surplus.

The forecast outturn for 2026/27 is a deficit of £77.4m, representing a £9.2m improvement against the submitted financial plan following confirmation of the reduction in the Health Board's Welsh Risk Pool contribution.

The forecast remains dependent on the delivery of further financial mitigations, with material risks continuing in relation to the savings programme and the recurrent financial position. The Welsh Risk Pool adjustment has also been assumed to provide a recurrent benefit to the underlying position.

In summary

- There is an urgent need to de-risk the plan.
- The reported year to date position is an overspend of £46.4m with a revised forecast deficit of £77.4m.
- At month 6 there is adverse variance against the revised forecast deficit of £7.7m, as a result of the £10.3m savings deficit and an operational surplus against plan of (£2.6m).
- There are schemes identified to deliver the core savings target of £42.5m. £27.0m of the schemes are categorised as green and amber, however, there is a significant associated delivery risk linked to £20.4m of the red-rated schemes. Further work is being progressed with JCC to identify opportunities to address the additional £5.1m JCC 2% efficiency target.

CHRIS BOWN
INTERIM CHIEF EXECUTIVE
13th October 2026

CATHERINE PHILLIPS
EXECUTIVE DIRECTOR OF FINANCE
13th October 2026

Annex 1.

Reconciliation of Unplanned Spend Reductions & Unplanned Cost Pressures Year-to-Date.

	Section A: Primary Care Contractor (excluding drugs, including non resource limited expenditure)	Section B: Primary Care - Drugs & Appliances	Section C: Provided Services - Pay	Section D: Provider Services - Non Pay (excluding drugs & depreciation)	Section E: Secondary Care - Drugs	Section F: Healthcare Services Provided by Other NHS Bodies	Section G: Non Healthcare Services Provided by Other NHS Bodies	Section H: Continuing Care and Funded Nursing Care	Section I: Other Private & Voluntary Sector	Section J: Joint Financing and Other	Total	Comments
Unplanned Spend Reductions (i.e. re-assessment of original planned spend assumption) (Negative Value)												
Medicine Endoscopy Insourcing											0	
Medicine Endoscopy Insourcing											0	
Mental Health OOA Placements											0	
Specialist Medical Locum Usage			(850)								(850)	Increased activity partially netting off locum usage
Specialist private patient activity reductions											0	
Ongoing high Wet AMD activity and income				(375)							(375)	Netted off by below
Vacancies and other net pay underspends			(4,290)								(4,290)	Expected to continue with further vacancies held
Continuing Healthcare demand											0	
Resident Doctors Contract											0	
LHB Expenditure Reduction & JCC Commissioner						(1,100)					(1,100)	To continue
Medicines Management (Primary Care & NICE)		(1,400)									(1,400)	To continue
Total Unplanned Spend Reductions	0	(1,400)	(5,140)	(375)	0	(1,100)	0	0	0	0	(8,015)	
Unplanned Cost Pressures (b/d required in narrative) (Positive Value)												
Medicine Endoscopy Insourcing				1,100							1,100	To cease from Month 7
Medicine Endoscopy Insourcing											0	
Mental Health OOA Placements									1,200		1,200	To continue at a reduced level
Specialist Medical Locum Usage			1,450								1,450	Partially netted off by increased activity
Specialist private patient activity reductions				700							700	To continue at current level
Ongoing high Wet AMD activity and income				375							375	Netting off previously reported spend reduction
Vacancies and other net pay underspends			290								290	
Continuing Healthcare demand											0	
Resident Doctors Contract			300								300	To continue at current level to end of the year
LHB Expenditure Reduction & JCC Commissioner											0	
Medicines Management (Primary Care & NICE)											0	
Total Unplanned Cost Pressures	0	0	2,040	2,175	0	0	0	0	1,200	0	5,415	
Table B2 Total Unplanned Spend Reductions/Cost Pressures												
Medicine Endoscopy Insourcing	0	0	0	1,100	0	0	0	0	0	0	1,100	
Medicine Endoscopy Insourcing	0	0	0	0	0	0	0	0	0	0	0	
Mental Health OOA Placements	0	0	0	0	0	0	0	0	1,200	0	1,200	
Specialist Medical Locum Usage	0	0	600	0	0	0	0	0	0	0	600	
Specialist private patient activity reductions	0	0	0	700	0	0	0	0	0	0	700	
Ongoing high Wet AMD activity and income	0	0	0	0	0	0	0	0	0	0	0	
Vacancies and other net pay underspends	0	0	(4,000)	0	0	0	0	0	0	0	(4,000)	
Continuing Healthcare demand	0	0	0	0	0	0	0	0	0	0	0	
Resident Doctors Contract	0	0	300	0	0	0	0	0	0	0	300	
LHB Expenditure Reduction & JCC Commissioner	0	0	0	0	0	(1,100)	0	0	0	0	(1,100)	
Medicines Management (Primary Care & NICE)	0	(1,400)	0	0	0	0	0	0	0	0	(1,400)	
Grand Total	0	(1,400)	(3,100)	1,800	0	(1,100)	0	0	1,200	0	(2,600)	

Reconciliation of Unplanned Spend Reductions & Unplanned Cost Pressures Forecast.

	Section A: Primary Care Contractor (excluding drugs, including non resource limited expenditure)	Section B: Primary Care - Drugs & Appliances	Section C: Provided Services - Pay	Section D: Provider Services - Non Pay (excluding drugs & depreciation)	Section E: Secondary Care - Drugs	Section F: Healthcare Services Provided by Other NHS Bodies	Section G: Non Healthcare Services Provided by Other NHS Bodies	Section H: Continuing Care and Funded Nursing Care	Section I: Other Private & Voluntary Sector	Section J: Joint Financing and Other	Total	Comments
Unplanned Spend Reductions (i.e. re-assessment of original planned spend assumption) (Negative Value)												
Medicine Endoscopy Insourcing											0	
Medicine Endoscopy Insourcing											0	
Mental Health OOA Placements											0	
Specialist Medical Locum Usage			(360)								(360)	
Ongoing high Wet AMD activity and income				(375)							(375)	
Specialist private patient activity reductions											0	
Vacancies and other net pay underspends			(9,100)								(9,100)	
Continuing Healthcare demand											0	
Resident Doctors Contract											0	
LHB Expenditure Reduction & JCC Commissioner						(1,900)					(1,900)	
Medicines Management (Primary Care & NICE)		(2,800)									(2,800)	
Programme Slippage (incl. Value)				(1,000)							(1,000)	
Release of Deferred R&D Income				(500)							(500)	
Procurement Opportunities				(900)							(900)	
Total Unplanned Spend Reductions	0	(2,800)	(9,460)	(2,775)	0	(1,900)	0	0	0	0	(16,935)	
Unplanned Cost Pressures (b/d required in narrative) (Positive Value)												
Medicine Endoscopy Insourcing				1,100							1,100	
Medicine Endoscopy Insourcing			200								200	
Mental Health OOA Placements									1,400		1,400	
Specialist Medical Locum Usage			1,160								1,160	
Ongoing high Wet AMD activity and income				375							375	
Specialist private patient activity reductions				1,400							1,400	
Vacancies and other net pay underspends											0	
Continuing Healthcare demand											0	
Resident Doctors Contract			1,200								1,200	
LHB Expenditure Reduction & JCC Commissioner											0	
Medicines Management (Primary Care & NICE)											0	
Programme Slippage (incl. Value)											0	
Release of Deferred R&D Income											0	
Procurement Opportunities											0	
Total Unplanned Cost Pressures	0	0	2,560	2,875	0	0	0	0	1,400	0	6,835	
Table B2 Total Unplanned Spend Reductions/Cost Pressures												
Medicine Endoscopy Insourcing	0	0	0	1,100	0	0	0	0	0	0	1,100	
Medicine Endoscopy Insourcing	0	0	200	0	0	0	0	0	0	0	200	
Mental Health OOA Placements	0	0	0	0	0	0	0	0	1,400	0	1,400	
Specialist Medical Locum Usage	0	0	800	0	0	0	0	0	0	0	800	
Ongoing high Wet AMD activity and income	0	0	0	0	0	0	0	0	0	0	0	
Specialist private patient activity reductions	0	0	0	1,400	0	0	0	0	0	0	1,400	
Vacancies and other net pay underspends	0	0	(9,100)	0	0	0	0	0	0	0	(9,100)	
Continuing Healthcare demand	0	0	0	0	0	0	0	0	0	0	0	
Resident Doctors Contract	0	0	1,200	0	0	0	0	0	0	0	1,200	
LHB Expenditure Reduction & JCC Commissioner	0	0	0	0	0	(1,900)	0	0	0	0	(1,900)	
Medicines Management (Primary Care & NICE)	0	(2,800)	0	0	0	0	0	0	0	0	(2,800)	
Programme Slippage (incl. Value)	0	0	0	(1,000)	0	0	0	0	0	0	(1,000)	
Release of Deferred R&D Income	0	0	0	(500)	0	0	0	0	0	0	(500)	
Procurement Opportunities	0	0	0	(900)	0	0	0	0	0	0	(900)	
Grand Total	0	(2,800)	(6,900)	100	0	(1,900)	0	0	1,400	0	(10,100)	

Cardiff & Vale ULHB **Period : Sep 26**

Table A - Movement of Opening Financial Plan to Forecast Outturn

This Table is currently showing 1 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 £'000	Non Recurring £'000	Recurring £'000	FYE of Recurring £'000		Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	YTD £'000	In Year Effect £'000
1	Underlying Position b/fwd from Previous Year - must agree to M12 MMR (Deficit - Negative Value)	-68,759	0	-68,759	-68,759	1	-5,730	-5,730	-5,730	-5,730	-5,730	-5,730	-5,730	-5,730	-5,730	-5,730	-5,730	-5,730	-34,380	-68,759
2	Cost Pressures (Negative Value)	-76,190	0	-76,190	-76,190	2	-6,349	-6,349	-6,349	-6,349	-6,349	-6,349	-6,349	-6,349	-6,349	-6,349	-6,349	-6,349	-38,095	-76,190
3	Allocation Letter Revenue Funding Uplift / WG RRL / WG Income Uplift	13,981	0	13,981	13,981	3	1,165	1,165	1,165	1,165	1,165	1,165	1,165	1,165	1,165	1,165	1,165	1,165	6,991	13,981
4	Other Income Uplift / (Reduction)	1,900	0	1,900	1,900	4	158	158	158	158	158	158	158	158	158	158	158	158	950	1,900
5	RRL Profile - phasing only (in-year effect should total nil /Column C)	0	0	0	0	5	-114	186	136	100	92	27	115	105	69	95	95	-906	426	0
6	Planned (Finalised) Green and Amber Savings Plan	12,637	4,363	8,273	8,416	6	1,033	878	924	960	975	1,040	952	962	998	972	972	1,973	5,810	12,637
7	Planned (Finalised) Net Income Generation	450	350	100	0	7	172	26	31	31	24	24	24	24	24	24	24	24	307	450
8	Planned Profit / (Loss) on Disposal of Assets	0	0	0	0	8													0	0
9	Planned Release of Uncommitted Contingencies & Reserves (Positive Value)	0	0			9													0	0
10		0	0			10													0	0
11	Red, Pipeline and Planning Assumption Savings still to be finalised at Month 1	29,434	0	29,434	34,105	11	2,453	2,453	2,453	2,453	2,453	2,453	2,453	2,453	2,453	2,453	2,453	2,453	14,717	29,434
12	**Opening IMTP / Annual Operating Plan**	**-86,547**	**4,713**	**-91,261**	**-86,547**	12	**-7,212**	**-7,212**	**-7,212**	**-7,212**	**-7,212**	**-7,212**	**-7,212**	**-7,212**	**-7,212**	**-7,212**	**-7,212**	**-7,213**	**-43,274**	**-86,547**
13	Reversal of Red, Pipeline and Planning Assumption Savings still to be finalised at Month 1	-29,434	0	-29,434	-34,105	13	-2,453	-2,453	-2,453	-2,453	-2,453	-2,453	-2,453	-2,453	-2,453	-2,453	-2,453	-2,453	-14,717	-29,434
14	Additional In Year & Movement from Planned Profit / (Loss) on Disposal of Assets	0	0			14													0	0
15	Other Movement in Month 1 Planned & In Year Net Income Generation	664	470	194	299	15	0	19	19	48	111	64	64	64	64	64	64	83	261	664
16	Other Movement in Month 1 Planned Savings - (Underachievement) / Overachievement	-609	-74	-535	718	16	-32	-30	89	-73	-72	-73	-73	-73	-68	-68	-68	-68	-191	-609
17	Additional In Year Identified Savings - Forecast	13,749	4,694	9,056	11,250	17	0	100	369	1,242	1,326	1,199	1,568	1,506	1,462	1,484	1,456	2,037	4,237	13,749
18	Variance to Planned RRL	-36	-36			18	55	97	1,018	565	-43	989	-564	-340	-301	-323	-295	-895	2,682	-36
19	Additional In Year & Movement in Planned Welsh Government Funding & Other Income (Positive Value - additional)	4,091	4,091		4,091	19			-1,272	-424	-424	4,165	341	341	341	341	341	341	2,046	4,091
20	In Year Accountancy Gains	162	162	0	0	20	0	0	0	0	0	0	162	0	0	0	0	0	0	162
21	Unplanned Spend Reductions	16,935	16,935	0	0	21	391	892	2,361	1,390	1,910	1,071	1,487	1,487	1,487	1,487	1,487	1,487	8,015	16,935
22	Unplanned Cost Pressures	-6,835	-6,835	0	0	22	-145	-814	-1,196	-1,552	-720	-988	-237	-237	-237	-237	-237	-237	-5,415	-6,835
23	Planned Mitigations Yet To Be Finalised	5,405	-10,072	15,477	21,838	23	0	0	0	0	0	0	901	901	901	901	901	901	0	5,405
24	Unplanned Additional Required Mitigations Yet To Be Finalised	5,087	0	5,087	5,087	24	0	0	0	0	0	0	848	848	848	848	848	848	0	5,087
25	Other	0	0	0	0	25	0	0	0	0	0	0	0	0	0	0	0	0	0	0
26		0	0			26													0	0
27		0	0			27													0	0
28		0	0			28													0	0
29		0	0			29													0	0
30		0	0			30													0	0
31		0	0			31													0	0
32		0	0			32													0	0
33		0	0			33													0	0
34		0	0			34													0	0
35	**Forecast Outturn (- Deficit / + Surplus)**	**-77,369**	**14,047**	**-91,416**	**-77,369**	35	**-9,396**	**-9,401**	**-8,276**	**-8,469**	**-7,577**	**-3,238**	**-5,169**	**-5,169**	**-5,169**	**-5,169**	**-5,169**	**-5,169**	**-46,356**	**-77,369**

Cardiff & Vale ULHB

Period : Sep 26

This Table is currently showing 0 errors

	Table A2 - Overview Of Key Risks & Opportunities	FORECAST YEAR END £'000	Likelihood
	Pressures Not Assumed in the Forecast Outturn (Negative Values):		
1	Continuing Healthcare		
2	Out of Area Mental Health Placements		
3	Primary Care Drugs		
4	Secondary Care Drugs including NICE		
5	Joint Commissioning Committee - Outturn Risk		
6	Joint Commissioning Committee - Contract Performance	0	Medium
7	ePMA - £516k contingency funding 26/27 as per original WG Business Case assumed	(516)	Medium
8	Student Streamliners Recruitment	TBC	Medium
9			
10			
11			
12			
13			
14			
15			
16			
17			
18	**Benefits Assumed in the Forecast Outturn at Risk (Negative Values):**		
19	Under delivery of Amber Schemes included in Outturn via Tracker		
20	Non Delivery of Planned Mitigations Yet To Be Finalised		
21	Non Delivery of Unplanned Additional Required Mitigations Yet To Be Finalised	(5,087)	Medium
22	GMS Ring Fenced Allocation Underspend Potential Claw back		
23	Dental Ring Fenced Allocation Underspend Potential Claw back		
24	Assumed Resident Doctor Funing	(576)	Medium
25			
26			
27	**Total Risks**	(6,179)	
	Opportunities Not Factored into the Forecast Outturn (Positive Values)		
28			
29			
30			
31			
32			
33			
34			
35	**Total Further Opportunities**	0	
36	**Current Reported Forecast Outturn**	(77,369)	
37	**Worst Case Outturn Scenario**	(83,548)	
38	**Best Case Outturn Scenario (Opportunities Only)**	(77,369)	

Cardiff & Vale ULHB

Period : Sep 26

Table C - Identified Expenditure Savings Schemes (Excludes Income Generation & Accountancy Gains)

Some errors will be resolved when complete rows have data or associated tables are completed

			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	179	165	124	143	143	141	123	123	123	123	123	123	895	1,634		1,434	200			
2		Actual/F'cast	179	218	412	650	666	553	708	683	629	629	628	628	2,678	6,582	40.69%	5,876	706	2,538	4,044	5,219
3		Variance	0	53	288	507	523	412	585	560	506	506	505	505	1,783	4,948	*199.11%*	4,442	506			
4	Non-Pay	Budget/Plan	512	357	419	395	395	406	326	326	337	326	326	1,312	2,484	5,435		4,820	615			
5		Actual/F'cast	454	328	413	531	507	601	661	715	739	748	728	2,288	2,833	8,713	32.52%	8,567	146	4,976	3,737	4,174
6		Variance	(58)	(29)	(6)	136	111	195	335	390	402	422	402	977	349	3,278	*14.05%*	3,747	-469			
7	Primary Care - Drugs & Appliances	Budget/Plan	97	97	97	100	100	101	101	101	101	101	101	101	590	1,195		1,195	0			
8		Actual/F'cast	122	124	123	126	126	126	181	181	181	183	183	183	746	1,839	40.58%	1,832	7	0	1,839	2,192
9		Variance	25	28	26	26	26	25	80	80	80	82	82	82	156	644	*26.49%*	637	7			
10	Secondary Care Drugs	Budget/Plan	163	178	203	198	213	268	278	288	313	298	298	313	1,224	3,014		3,014	0			
11		Actual/F'cast	164	196	294	458	660	618	533	534	559	544	544	559	2,391	5,666	42.19%	5,666	0	1,189	4,477	5,672
12		Variance	1	18	91	260	447	350	255	246	246	246	246	246	1,167	2,652	*95.37%*	2,652	0			
13	CHC/FNC	Budget/Plan	82	82	82	124	124	124	124	124	124	124	124	124	617	1,359		1,259	100			
14		Actual/F'cast	82	82	142	342	248	245	328	245	248	248	241	248	1,141	2,698	42.29%	2,698	0	0	2,698	3,023
15		Variance	0	0	60	218	124	122	204	122	124	124	117	124	524	1,339	*84.91%*	1,439	-100			
16	Primary Care Contractor	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
17		Actual/F'cast	0	0	0	0	0	0	13	13	13	13	13	13	0	80	0.00%	80	0	80	0	0
18		Variance	0	0	0	0	0	0	13	13	13	13	13	13	0	80		80	0			
19	Healthcare Services Provided by Other Healthboards	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
20		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
21		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		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	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
26		Actual/F'cast	0	0	0	22	22	22	22	22	22	22	22	22	67	200	33.33%	200	0	200	0	0
27		Variance	0	0	0	22	22	22	22	22	22	22	22	22	67	200		200	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	1,033	878	924	960	975	1,040	952	962	998	972	972	1,973	5,810	12,637		11,722	0			
35		Actual/F'cast	1,001	948	1,383	2,129	2,229	2,166	2,446	2,395	2,391	2,388	2,360	3,942	9,856	25,777		24,918	859	8,983	16,794	20,279
36		Variance	(32)	70	459	1,169	1,254	1,126	1,495	1,433	1,394	1,416	1,388	1,969	4,046	13,140		13,196	859			
37	Variance in month		(3.12%)	7.99%	49.64%	121.79%	128.58%	108.30%	157.09%	149.01%	139.72%	145.74%	142.86%	99.81%	69.63%							
38	In month achievement against FY forecast		3.88%	3.68%	5.36%	8.26%	8.65%	8.40%	9.49%	9.29%	9.28%	9.26%	9.15%	15.29%								

Cardiff & Vale ULHB

Period : Sep 26

Table C1- Savings Schemes Pay Analysis

		Month	1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			Green	Amber	non recurring	recurring	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000			£'000	£'000	£'000	£'000	
1		Budget/Plan	179	165	124	121	121	118	101	101	101	101	101	101	829	1,434	1,434	0			
2	Pay - General & Substantive	Actual/F'cast	179	218	406	608	586	459	614	525	472	472	470	470	2,457	5,480	4,909	571	2,459	3,021	3,755
3		Variance	0	53	282	487	465	341	513	424	371	371	369	369	1,628	4,046	3,475	571			
4		Budget/Plan	0	0	0	22	22	22	22	22	22	22	22	22	67	200	0	200			
5	Pay - Variable	Actual/F'cast	0	0	5	42	80	94	94	157	157	157	157	157	221	1,102	967	135	80	1,023	1,464
6		Variance	0	0	5	20	58	72	72	135	135	135	135	135	155	902	967	(65)			
7		Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
8	Pay - Agency	Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
9		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
10		Budget/Plan	179	165	124	143	143	141	123	123	123	123	123	123	895	1,634	1,434	200			
11	Total	Actual/F'cast	179	218	412	650	666	553	708	683	629	629	628	628	2,678	6,582	5,876	706	2,538	4,044	5,219
12		Variance	0	53	288	507	523	412	585	560	506	506	505	505	1,783	4,948	4,442	506			

Cardiff & Vale ULHB

Sep 26

Table C2 Summary

	£'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	1,033	878	924	960	975	1,040	952	962	998	972	972	1,973	5,810	12,637	4,363	8,273	142	8,416
	Month 1 - Actual/Forecast	1,001	849	1,013	887	903	966	878	888	930	904	904	1,905	5,619	12,028	4,290	7,738	1,396	9,134
	Variance	(32)	(30)	89	(73)	(72)	(73)	(73)	(73)	(68)	(68)	(68)	(68)	(191)	(609)	(74)	(535)	1,253	718
	In Year - Plan	5	95	341	987	1,129	1,023	1,003	1,548	1,590	1,617	1,614	2,371	3,580	13,323	4,109	9,214	(2,117)	7,097
	In Year - Actual/Forecast	0	100	369	1,242	1,326	1,199	1,568	1,506	1,462	1,484	1,456	2,037	4,237	13,749	4,694	9,056	2,194	11,250
	Variance	(5)	5	28	256	196	176	565	(42)	(128)	(133)	(159)	(334)	656	426	585	(159)	4,311	4,153
	Total Plan	1,038	973	1,265	1,947	2,105	2,063	1,954	2,510	2,588	2,589	2,586	4,343	9,390	25,960	8,472	17,487	(1,974)	15,513
	Total Actual/Forecast	1,001	948	1,383	2,129	2,229	2,166	2,446	2,395	2,391	2,388	2,360	3,942	9,856	25,777	8,983	16,794	3,590	20,384
	Total Variance	(38)	(24)	117	183	124	103	492	(115)	(196)	(201)	(226)	(402)	465	(183)	511	(694)	5,565	4,871
Net Income Generation	Month 1 - Plan	172	26	31	31	24	24	24	24	24	24	24	24	307	450	350	100	(100)	0
	Month 1 - Actual/Forecast	172	26	31	57	24	24	24	24	24	24	24	24	333	476	376	100	0	100
	Variance	0	0	0	26	0	0	0	0	0	0	0	0	26	26	26	0	100	100
	In Year - Plan	0	19	19	30	104	72	64	64	64	64	64	83	244	646	447	199	(139)	60
	In Year - Actual/Forecast	0	19	19	22	111	64	64	64	64	64	64	83	235	638	444	194	5	199
	Variance	0	0	0	(8)	7	(8)	0	0	0	0	0	0	(9)	(9)	(4)	(5)	144	139
	Total Plan	172	45	50	60	128	96	88	88	88	88	88	107	551	1,096	797	299	(239)	60
	Total Actual/Forecast	172	45	50	79	135	88	88	88	88	88	88	107	568	1,113	819	294	5	299
	Total Variance	0	0	0	18	7	(8)	0	0	0	0	0	0	17	17	22	(5)	244	239
Accountancy Gains	In Year - Plan	0	0	0	0	0	0	162	0	0	0	0	0	0	162	162	0	0	0
	In Year - Actual/Forecast	0	0	0	0	0	0	162	0	0	0	0	0	0	162	162	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	Month 1 - Plan	1,205	905	955	991	999	1,063	975	985	1,021	995	995	1,996	6,117	13,087	4,713	8,373	42	8,416
	Month 1 - Actual/Forecast	1,173	875	1,044	944	927	990	902	912	953	927	927	1,929	5,952	12,504	4,665	7,838	1,396	9,234
	Variance	(32)	(30)	89	(47)	(72)	(73)	(73)	(73)	(68)	(68)	(68)	(68)	(165)	(583)	(48)	(535)	1,353	818
	In Year - Plan	5	113	360	1,016	1,234	1,095	1,228	1,612	1,654	1,681	1,678	2,453	3,824	14,131	4,718	9,413	(2,256)	7,157
	In Year - Actual/Forecast	0	118	389	1,264	1,437	1,263	1,794	1,570	1,526	1,548	1,520	2,120	4,472	14,548	5,299	9,250	2,200	11,449
	Variance	(5)	5	28	248	203	168	565	(42)	(128)	(133)	(159)	(334)	648	417	581	(164)	4,455	4,292
	Total Plan	1,210	1,018	1,315	2,007	2,233	2,158	2,204	2,597	2,676	2,676	2,674	4,450	9,941	27,218	9,431	17,787	(2,213)	15,573
	Total Actual/Forecast	1,173	993	1,433	2,208	2,364	2,253	2,696	2,482	2,479	2,475	2,447	4,048	10,424	27,052	9,964	17,088	3,595	20,683
	Total Variance	(38)	(24)	117	201	131	95	492	(115)	(196)	(201)	(226)	(402)	483	(166)	533	(699)	5,809	5,110

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	3,219	2,220	0	**5,439**	488	162
Scheduled Care	2,102	9,685	0	**11,787**	486	0
Unscheduled Care	348	0	0	**348**	0	0
Mental Health	177	544	0	**721**	0	0
Community Services	54	910	0	**964**	0	0
Primary Care	20	1,974	0	**1,994**	0	0
Commissioned Services - CHC	0	2,553	0	**2,553**	0	0
Commissioned Services - Specialised Services	0	569	0	**569**	0	0
Other Commissioned Services	0	0	0	**0**	0	0
Clinical Support	85	0	0	**85**	120	0
Non Clinical Support	88	0	0	**88**	0	0
Executive / Corporate Areas	459	741	0	**1,200**	0	0
Total	**6,553**	**19,195**	**0**	**25,748**	**1,094**	**162**

ID	Organisation	Scheme / Opportunity Title	Division	Business Unit	Recurrent (R) / Non Recurrent (NR)	Definition	Current Year Annual Plan £'000	Plan FYE (Recurring Schemes only) £'000	Current Year Forecast £'000	Scheme Identified: By Month 1 or In Year (AG only In Year)	Forecast FYE (Recurring Schemes only) £'000	Scheme Start Date	Scheme RAG rating
1	Cardiff & Vale ULHB	CHFW - Annual Leave Purchase	Children and Women	CHFW	NR	Cash-Releasing Saving	18	0	18	Month 1	0	01-Apr-26	Green
2	Cardiff & Vale ULHB	O&G - Annual Leave Purchase	Children and Women	O&G	NR	Cash-Releasing Saving	16	0	22	Month 1		01-Apr-26	Green
3	Cardiff & Vale ULHB	CYPFHS - Annual Leave Purchase	Children and Women	CYPFHS	NR	Cash-Releasing Saving	42	0	72	Month 1		01-Apr-26	Green
4	Cardiff & Vale ULHB	CHFW - Centralised Ward Stockholding	Children and Women	CHFW	R	Cash-Releasing Saving	25	25	0	Month 1		01-Apr-26	Amber
5	Cardiff & Vale ULHB	CYPFHS - Review of Stock Issued	Children and Women	CYPFHS	R	Cash-Releasing Saving	90	90	0	Month 1	0	01-Apr-26	Amber
6	Cardiff & Vale ULHB	CHFW - Dexcom Diabetes Rebate	Children and Women	CHFW	NR	Cash-Releasing Saving	60	0	60	Month 1		01-Jun-26	Green
7	Cardiff & Vale ULHB	CHFW - LTS Resolution	Children and Women	CHFW	R	Cash-Releasing Saving	149	198	149	Month 1	198	01-Apr-26	Green
8	Cardiff & Vale ULHB	CYPFHS - Respite (Glan Ely CHC)	Children and Women	CYPFHS	R	Cash-Releasing Saving	100	100	0	Month 1		01-Apr-26	Amber
9	Cardiff & Vale ULHB	CYPFHS - Band 4 CCNS	Children and Women	CYPFHS	R	Cash-Releasing Saving	40	40	40	Month 1	40	01-Apr-26	Green
10	Cardiff & Vale ULHB	CHFW - Overpayments Reductions	Children and Women	CHFW	R	Cash-Releasing Saving	90	90	90	Month 1	90	01-Apr-26	Green
11	Cardiff & Vale ULHB	PSU Closure	Clinical Diagnostics and Therapeutics	PHARMACY & MEDICINE'S MANAGEMENT GENERAL	R	Cash-Releasing Saving	150	200	150	Month 1	200	01-Jul-26	Green
12	Cardiff & Vale ULHB	Rental of mobile MRI Q1 - Swansea Bay	Clinical Diagnostics and Therapeutics	CLINICAL DIAGNOSTICS AND THERAPEUTICS MANAGEMENT	NR	Cash-Releasing Saving	60	0	60	Month 1	0	01-Apr-26	Green
13	Cardiff & Vale ULHB	CDC benefit once performance levels have improved	Clinical Diagnostics and Therapeutics	CLINICAL DIAGNOSTICS AND THERAPEUTICS MANAGEMENT	R	Cash-Releasing Saving	500	500	0	Month 1	0	01-Apr-26	Amber
14	Cardiff & Vale ULHB	Pharmacist secondment income (Apr-May)	Clinical Diagnostics and Therapeutics	PHARMACY & MEDICINE'S MANAGEMENT GENERAL	NR	Cash-Releasing Saving	9	0	9	Month 1	0	01-Apr-26	Green
15	Cardiff & Vale ULHB	Off-contract income	Clinical Diagnostics and Therapeutics	PHARMACY & MEDICINE'S MANAGEMENT GENERAL	NR	Income Generation	50	0	50	Month 1	0	01-Apr-26	Green
16	Cardiff & Vale ULHB	Skill mix - 1.00wte Band 7 to 1.00wte Band 6	Clinical Diagnostics and Therapeutics	PHYSIOTHERAPY	NR	Cash-Releasing Saving	12	0	12	Month 1	0	01-Apr-26	Green
17	Cardiff & Vale ULHB	Vacancy - 0.42wte Band 3 - Recurrent Element	Clinical Diagnostics and Therapeutics	PHYSIOTHERAPY	NR	Cash-Releasing Saving	14	0	14	Month 1	0	01-Apr-26	Green
18	Cardiff & Vale ULHB	Maternity microbio tests	Clinical Diagnostics and Therapeutics	HAEMATOLOGY	R	Cash-Releasing Saving	3	3	3	Month 1	3	01-Apr-26	Green
19	Cardiff & Vale ULHB	Rental of mobile MRI Q2	Clinical Diagnostics and Therapeutics	CLINICAL DIAGNOSTICS AND THERAPEUTICS MANAGEMENT	NR	Cash-Releasing Saving	60	0	60	Month 1	0	01-Jul-26	Green
20	Cardiff & Vale ULHB	Reagent Purchases Biochemistry	Clinical Diagnostics and Therapeutics	CLINICAL DIAGNOSTICS AND THERAPEUTICS MANAGEMENT	NR	Cash-Releasing Saving	300	0	375	Month 1	0	01-Apr-26	Green
21	Cardiff & Vale ULHB	Blood Gas Analyser contract renewal	Clinical Diagnostics and Therapeutics	HAEMATOLOGY	R	Cash-Releasing Saving	50	50	50	Month 1	50	01-Apr-26	Green
22	Cardiff & Vale ULHB	B7 Maternity backfill	Clinical Diagnostics and Therapeutics	MBI	R	Cash-Releasing Saving	12	12	12	Month 1	12.21	01-Apr-26	Green
23	Cardiff & Vale ULHB	Third Party Abbott - Roche Platform	Clinical Diagnostics and Therapeutics	MBI	R	Cash-Releasing Saving	249	249	160	Month 1	160.0479	01-Jul-26	Green
24	Cardiff & Vale ULHB	Replacement of Horiba Analysers in Haematology MSC	Clinical Diagnostics and Therapeutics	HAEMATOLOGY	R	Cash-Releasing Saving	87	87	43	Month 1	86.59956	01-Jul-26	Green
25	Cardiff & Vale ULHB	Cleanroom Clothing - SMPU	Clinical Diagnostics and Therapeutics	ST MARY'S PHARMACEUTICAL UNIT	R	Cash-Releasing Saving	27	27	25	Month 1	27.2238	01-Apr-26	Green
26	Cardiff & Vale ULHB	Replacement of Griffols Abalysers in Haematology MSC	Clinical Diagnostics and Therapeutics	HAEMATOLOGY	R	Cash-Releasing Saving	42	42	35	Month 1	42.397	01-Aug-26	Green
27	Cardiff & Vale ULHB	Genmed credits to Aug 25 net of Horiba termination fee	Clinical Diagnostics and Therapeutics	HAEMATOLOGY	NR	Cash-Releasing Saving	50	0	65	Month 1	0	01-Jun-26	Green
28	Cardiff & Vale ULHB	Biochem External Tests/Income	Clinical Diagnostics and Therapeutics	MBI	NR	Income Generation	30	0	30	Month 1	0	01-Apr-26	Green
29	Cardiff & Vale ULHB	Maintenance of Water Generation System	Clinical Diagnostics and Therapeutics	ST MARY'S PHARMACEUTICAL UNIT	R	Cash-Releasing Saving	0	0	0	Month 1	0.498	01-Aug-26	Green
30	Cardiff & Vale ULHB	Vacancies as a result of scrutiny process	Clinical Diagnostics and Therapeutics	CLINICAL DIAGNOSTICS AND THERAPEUTICS MANAGEMENT	NR	Cash-Releasing Saving	200	0	200	Month 1		01-Apr-26	Green

ID	Organisation	Scheme / Opportunity Title	Division	Business Unit	Recurrent (R) / Non Recurrent (NR)	Definition	Current Year Annual Plan £'000	Plan FYE (Recurring Schemes only) £'000	Current Year Forecast £'000	Scheme Identified: By Month 1 or In Year (AG only In Year)	Forecast FYE (Recurring Schemes only) £'000	Scheme Start Date	Scheme RAG rating
31	Cardiff & Vale ULHB	R&D parkinsos AskBio Trial x 5 patients	Clinical Diagnostics and Therapeutics	RADIOLOGY	NR	Income Generation	135	0	161	Month 1	0	01-Apr-26	Green
32	Cardiff & Vale ULHB	Cell Path SLA	Clinical Diagnostics and Therapeutics	CELLULAR PATHOLOGY	NR	Cash-Releasing Saving	24	0	24	Month 1	0	01-Apr-26	Green
33	Cardiff & Vale ULHB	Pharmacist secondment income (Jun-Mar)	Clinical Diagnostics and Therapeutics	PHARMACY & MEDICINE'S MANAGEMENT GENERAL	NR	Income Generation	45	0	45	Month 1	0	01-Jun-26	Green
34	Cardiff & Vale ULHB	Reduction in Security Costs	Capital Estates and Facilities	Security	R	Cash-Releasing Saving	100	100	100	Month 1	100	01-Apr-26	Green
35	Cardiff & Vale ULHB	Waste pre-audit fees	Capital Estates and Facilities	Waste	R	Cash-Releasing Saving	4	4	4	Month 1	4	01-Apr-26	Green
36	Cardiff & Vale ULHB	VERS	Capital Estates and Facilities	Retail	R	Cash-Releasing Saving	46	49	46	Month 1	49	17-Apr-26	Green
37	Cardiff & Vale ULHB	VERS	Corporate Executives	Chief executive officer	R	Cash-Releasing Saving	45	49	45	Month 1	49	30-Apr-26	Green
38	Cardiff & Vale ULHB	VERS	Corporate Executives	Finance	R	Cash-Releasing Saving	60	70	60	Month 1	70	26-May-26	Green
39	Cardiff & Vale ULHB	COURSES AND CONFERENCES	Corporate Executives	Finance	R	Cash-Releasing Saving	14	14	14	Month 1	14	01-Apr-26	Green
40	Cardiff & Vale ULHB	PARTIAL RETIREMENT	Corporate Executives	Finance	R	Cash-Releasing Saving	39	39	39	Month 1	39	01-Apr-26	Green
41	Cardiff & Vale ULHB	Apremilast - generic version available - Rheum	Medicine	Specialised Medicine	R	Cash-Releasing Saving	300	300	300	Month 1	300	01-Sep-26	Green
42	Cardiff & Vale ULHB	Denosumab - biosimilars available - Bone Service	Medicine	Integrated medicine	R	Cash-Releasing Saving	350	220	350	Month 1	350	01-May-26	Green
43	Cardiff & Vale ULHB	Nintedanib - generic versions available - Respiratory	Medicine	Integrated medicine	R	Cash-Releasing Saving	290	500	290	Month 1	500	01-Jun-26	Green
44	Cardiff & Vale ULHB	Omalizumab - biosimilar available - Respiratory	Medicine	Integrated medicine	R	Cash-Releasing Saving	31	31	31	Month 1	31.167	01-Apr-26	Green
45	Cardiff & Vale ULHB	Ustekinumab - Wezenla to Steqeyma - Derm	Medicine	Specialised Medicine	R	Cash-Releasing Saving	46	46	46	Month 1	46.342	01-Apr-26	Green
46	Cardiff & Vale ULHB	Ustekinumab - Wezenla to Steqeyma - Rheum	Medicine	Specialised Medicine	R	Cash-Releasing Saving	9	9	9	Month 1	9.418	01-Apr-26	Green
47	Cardiff & Vale ULHB	Revised Management Structure	Medicine	All Areas	R	Cash-Releasing Saving	49	49	49	Month 1	49.369	01-Apr-26	Green
48	Cardiff & Vale ULHB	Fisher and Paykel consumables - price reduction	Medicine	Integrated medicine	R	Cash-Releasing Saving	1	1	1	Month 1	1.17	01-Apr-26	Green
49	Cardiff & Vale ULHB	Gastro stock efficiencies	Medicine	Specialised Medicine	NR	Cash-Releasing Saving	300	0	300	Month 1		01-Apr-26	Green
50	Cardiff & Vale ULHB	Ustekinumab	Medicine	All Areas	R	Cash-Releasing Saving	200	200	200	Month 1	200	01-Apr-26	Green
51	Cardiff & Vale ULHB	Vacancy Savings Q1	Medicine	All Areas	NR	Cash-Releasing Saving	199	0	199	Month 1		01-Apr-26	Green
52	Cardiff & Vale ULHB	High Cost CHC Dispute	Mental Health	Continuing Healthcare	R	Cash-Releasing Saving	884	884	884	Month 1	884	01-Apr-26	Green
53	Cardiff & Vale ULHB	External Room bookings review	Mental Health	Psychology and Psychological Therapies	R	Cash-Releasing Saving	10	10	10	Month 1	10	01-Jul-26	Green
54	Cardiff & Vale ULHB	Review of SIMA operating hours - Pilot	Mental Health	Adult Mental Health	R	Cash-Releasing Saving	115	115	115	Month 1	115.36	01-Jul-26	Green
55	Cardiff & Vale ULHB	Reduce staff sickness to target rate, improving availability and lowering temporary pay	Mental Health	Adult Mental Health	NR	Cash-Releasing Saving	200	0	0	Month 1		01-Jul-26	Amber
56	Cardiff & Vale ULHB	CHC Reviews	Mental Health	Continuing Healthcare	R	Cash-Releasing Saving	375	375	375	Month 1	375	01-Jul-26	Green
57	Cardiff & Vale ULHB	Risperidone Consta to Paliperidone	Mental Health	Adult Mental Health	R	Cash-Releasing Saving	3	3	7	Month 1	7	01-Jul-26	Green
58	Cardiff & Vale ULHB	Aripiprazole switch	Mental Health	Adult Mental Health	R	Cash-Releasing Saving	3	3	7	Month 1	7	01-Jul-26	Green
59	Cardiff & Vale ULHB	Armour Thyroid - UHB support to stop prescribing	Primary, Community and Intermediate Care	Medicines Management	R	Cash-Releasing Saving	12	12	12	Month 1	12	01-Apr-26	Green
60	Cardiff & Vale ULHB	NovoRapid to Trurapi (preferred brand of insulin aspart)	Primary, Community and Intermediate Care	Medicines Management	R	Cash-Releasing Saving	10	10	10	Month 1	10	01-Apr-26	Green

ID	Organisation	Scheme / Opportunity Title	Division	Business Unit	Recurrent (R) / Non Recurrent (NR)	Definition	Current Year Annual Plan £'000	Plan FYE (Recurring Schemes only) £'000	Current Year Forecast £'000	Scheme Identified: By Month 1 or In Year (AG only In Year)	Forecast FYE (Recurring Schemes only) £'000	Scheme Start Date	Scheme RAG rating
61	Cardiff & Vale ULHB	Reduction in weekend working (6 day service) (imms)	Primary, Community and Intermediate Care	Community Specialist Services	R	Cash-Releasing Saving	54	90	54	Month 1	90	01-Apr-26	Green
62	Cardiff & Vale ULHB	Mobile Phone contract switch	Primary, Community and Intermediate Care	Clinical Board Management	R	Cash-Releasing Saving	57	57	57	Month 1	57	01-Apr-26	Green
63	Cardiff & Vale ULHB	JES Transfer Efficiencies	Primary, Community and Intermediate Care	Clinical Board Management	R	Cash-Releasing Saving	55	55	55	Month 1	55	01-Apr-26	Green
64	Cardiff & Vale ULHB	Dapagliflozin loss of exclusivity	Primary, Community and Intermediate Care	Medicines Management	R	Cash-Releasing Saving	520	520	820	Month 1	820	01-Apr-26	Green
65	Cardiff & Vale ULHB	Transfer of Mobile Dental Unit	Primary, Community and Intermediate Care	Primary Care	R	Cash-Releasing Saving	20	20	20	Month 1	20	01-Apr-26	Green
66	Cardiff & Vale ULHB	Fostair to Proxor	Primary, Community and Intermediate Care	Medicines Management	R	Cash-Releasing Saving	136	136	136	Month 1	136	01-Apr-26	Green
67	Cardiff & Vale ULHB	Xigduo to individual dapagliflozin & metformin once daily	Primary, Community and Intermediate Care	Medicines Management	R	Cash-Releasing Saving	35	35	35	Month 1	35	01-Apr-26	Green
68	Cardiff & Vale ULHB	Empagliflozin 10mg to dapagliflozin 10mg	Primary, Community and Intermediate Care	Medicines Management	R	Cash-Releasing Saving	370	370	370	Month 1	370	01-Apr-26	Green
69	Cardiff & Vale ULHB	Blood glucose test strips Phase 4 & 5 (Wv +EV & CV)	Primary, Community and Intermediate Care	Medicines Management	R	Cash-Releasing Saving	6	6	6	Month 1	6	01-Apr-26	Green
70	Cardiff & Vale ULHB	rivaroxaban caps to tablets	Primary, Community and Intermediate Care	Medicines Management	R	Cash-Releasing Saving	15	15	15	Month 1	15	01-Apr-26	Green
71	Cardiff & Vale ULHB	Brilique (ticagrelor) LOE -	Primary, Community and Intermediate Care	Medicines Management	R	Cash-Releasing Saving	55	55	55	Month 1	55	01-Apr-26	Green
72	Cardiff & Vale ULHB	Blood glucose test strips Phase 6 &7 (SW & SE) - all clusters completed after this	Primary, Community and Intermediate Care	Medicines Management	R	Cash-Releasing Saving	5	5	5	Month 1	5	01-Jul-26	Green
73	Cardiff & Vale ULHB	generic methylphenidate XL 10/20/30/40/60mg to preferred brand Meflynate XL	Primary, Community and Intermediate Care	Medicines Management	R	Cash-Releasing Saving	13	13	13	Month 1	13	01-Jul-26	Green
74	Cardiff & Vale ULHB	Emeside 250mg capsules to generic ethosuxamide caps	Primary, Community and Intermediate Care	Medicines Management	R	Cash-Releasing Saving	9	12	9	Month 1	12	01-Jul-26	Green
75	Cardiff & Vale ULHB	Apremilast - generic version available	Primary, Community and Intermediate Care	Medicines Management	R	Cash-Releasing Saving	9	15	15	Month 1	15	01-Sep-26	Green
76	Cardiff & Vale ULHB	IBD Blood Product Clinical Trial Savings	Specialist Services	HIMM	NR	Cash-Releasing Saving	650	0	650	Month 1		01-Apr-26	Green
77	Cardiff & Vale ULHB	Haem Drug rebates	Specialist Services	HIMM	NR	Cash-Releasing Saving	220	0	220	Month 1		01-Apr-26	Green
78	Cardiff & Vale ULHB	Advanced Therapy Neuro trial	Specialist Services	Neurosciences	NR	Cash-Releasing Saving	100	0	100	Month 1		01-Apr-26	Green
79	Cardiff & Vale ULHB	CC RRT Contract Savings	Specialist Services	Critical Care	R	Cash-Releasing Saving	250	250	250	Month 1	250	01-Apr-26	Green
80	Cardiff & Vale ULHB	Heart & Lung machine maintenance contract	Specialist Services	Critical Care	R	Cash-Releasing Saving	100	100	100	Month 1	100	01-Jul-26	Green
81	Cardiff & Vale ULHB	Bulk Purchase rebates	Specialist Services	Cardiothoracic	NR	Cash-Releasing Saving	250	0	250	Month 1		01-Mar-27	Green
82	Cardiff & Vale ULHB	TAVI Medpoints	Specialist Services	Cardiothoracic	NR	Cash-Releasing Saving	100	0	100	Month 1		01-Mar-27	Green
83	Cardiff & Vale ULHB	Device Rebates	Specialist Services	Cardiothoracic	NR	Cash-Releasing Saving	400	0	400	Month 1		01-Mar-27	Green
84	Cardiff & Vale ULHB	8c Nurse Consultant post held	Specialist Services	Critical Care	NR	Cash-Releasing Saving	75	0	75	Month 1		01-Apr-26	Green
85	Cardiff & Vale ULHB	R&D Income opportunities	Specialist Services	Neurosciences	NR	Cash-Releasing Saving	125	0	125	Month 1		01-Mar-27	Green
86	Cardiff & Vale ULHB	DoO Temp reduction to 0.8	Specialist Services	Management	NR	Cash-Releasing Saving	30	0	30	Month 1		01-Apr-26	Green
87	Cardiff & Vale ULHB	Metabolic Meds Rebates	Specialist Services	HIMM	R	Cash-Releasing Saving	250	250	250	Month 1	250	01-Apr-26	Green
88	Cardiff & Vale ULHB	Reduce stock wastage	Specialist Services	Cardiothoracic	R	Cash-Releasing Saving	75	100	75	Month 1	100	01-Aug-26	Green
89	Cardiff & Vale ULHB	Maintenance contracts optimsation	Specialist Services	Cardiothoracic	NR	Cash-Releasing Saving	160	0	160	Month 1		01-Jun-26	Green
90	Cardiff & Vale ULHB	Reduce blood stock wastage	Specialist Services	HIMM	R	Cash-Releasing Saving	45	45	45	Month 1	45	01-Apr-26	Green

ID	Organisation	Scheme / Opportunity Title	Division	Business Unit	Recurrent (R) / Non Recurrent (NR)	Definition	Current Year Annual Plan £'000	Plan FYE (Recurring Schemes only) £'000	Current Year Forecast £'000	Scheme Identified: By Month 1 or In Year (AG only In Year)	Forecast FYE (Recurring Schemes only) £'000	Scheme Start Date	Scheme RAG rating
91	Cardiff & Vale ULHB	Additional device discount	Specialist Services	Cardiothoracic	NR	Cash-Releasing Saving	160	0	160	Month 1		01-Apr-26	Green
92	Cardiff & Vale ULHB	Historic B6/B5 nursing saving (A5S)	Surgery	T&O	R	Cash-Releasing Saving	15	15	15	Month 1	15	01-Apr-26	Green
93	Cardiff & Vale ULHB	Harmonic Scalpels/ Vanguard Catheters Income Generation	Surgery	Theatres, Anaesthetics, SSSU & Sterilisation Services	R	Income Generation	0	0	0	Month 1		01-Jul-26	
94	Cardiff & Vale ULHB	Stoma contract renewal	Surgery	General Surgery	R	Cash-Releasing Saving	130	0	130	Month 1	130	01-Apr-26	Green
95	Cardiff & Vale ULHB	Review Endocrine Service Pathway	Surgery	General Surgery	NR	Cash-Releasing Saving	132	0	132	Month 1		01-Apr-26	Green
96	Cardiff & Vale ULHB	Commission ROSA Knee Robot	Surgery	Theatres, Anaesthetics, SSSU & Sterilisation Services	R	Cash-Releasing Saving	89	89	89	Month 1	89	01-Apr-26	Green
97	Cardiff & Vale ULHB	Cessation of Amplitude contract	Surgery	T&O	R	Cash-Releasing Saving	28	30	28	Month 1	30	01-May-26	Green
98	Cardiff & Vale ULHB	Breast seeds	Surgery	T&O	NR	Cash-Releasing Saving	5	0	5	Month 1		01-Apr-26	Green
99	Cardiff & Vale ULHB	Historic B3/2 nursing saving (West 5)	Surgery	T&O	R	Cash-Releasing Saving	3	3	3	Month 1	3	01-Apr-26	Green
100	Cardiff & Vale ULHB	Historic B6/5 nursing saving (West 5)	Surgery	T&O	R	Cash-Releasing Saving	10	10	10	Month 1	10	01-Apr-26	Green
101	Cardiff & Vale ULHB	Change of sterile service traceaibility technology from HealthEdge to SSDman Aqua	Surgery	Theatres, Anaesthetics, SSSU & Sterilisation Services	NR	Cash-Releasing Saving	2	0	2	Month 1		01-Oct-26	Green
102	Cardiff & Vale ULHB	Product swaps	Surgery	Theatres, Anaesthetics, SSSU & Sterilisation Services	R	Cash-Releasing Saving	0	0	0	Month 1		01-Jul-26	
103	Cardiff & Vale ULHB	Fisher and Paykel commitment deal	Surgery	Theatres, Anaesthetics, SSSU & Sterilisation Services	R	Cash-Releasing Saving	0	0	0	Month 1		01-Jul-26	
104	Cardiff & Vale ULHB	Dalbavancin price reduction	Surgery	General Surgery	R	Cash-Releasing Saving	4	4	4	Month 1	4	01-May-26	Green
105	Cardiff & Vale ULHB	Dalbavancin price reduction	Surgery	T&O	R	Cash-Releasing Saving	47	47	47	Month 1	47	01-May-26	Green
106	Cardiff & Vale ULHB	IVT Patent Expiry	Surgery	Ophthalmology	R	Cash-Releasing Saving	800	800	809	Month 1	1650	01-Apr-26	Green
107	Cardiff & Vale ULHB	Temp closure of 9 beds on B6 (6 months)	Surgery	ENT	NR	Cash-Releasing Saving	105	0	105	Month 1		01-Apr-26	Green
108	Cardiff & Vale ULHB	Recover the cost of Skullbase sessions	Surgery	ENT	R	Cash-Releasing Saving	44	44	44	Month 1	44	01-Apr-26	Green
109	Cardiff & Vale ULHB	New supplier for Spinal Monitoring	Surgery	T&O	R	Cash-Releasing Saving	13	15	13	Month 1	15	01-Jun-26	Green
110	Cardiff & Vale ULHB	CTM IR SLA Income	Surgery	General Surgery	NR	Income Generation	82	0	82	Month 1		01-Apr-26	Green
111	Cardiff & Vale ULHB	Theatre consumable discounts obtained	Surgery	Theatres, Anaesthetics, SSSU & Sterilisation Services	NR	Cash-Releasing Saving	216	0	216	Month 1		01-Apr-26	Green
112	Cardiff & Vale ULHB	Cochlear purchase discounts and free processors	Surgery	Audiology	NR	Cash-Releasing Saving	56	0	56	Month 1		01-Apr-26	Green
113	Cardiff & Vale ULHB	Temporary Reduction in 2 Consultant sessions (Apr-Aug)	Surgery	Urology	NR	Cash-Releasing Saving	13	0	13	Month 1		01-Apr-26	Green
114	Cardiff & Vale ULHB	Recovery of Prior Approval & IPFR Income	Surgery	General Surgery	R	Income Generation	100	0	100	Month 1	100	01-Apr-26	Green
115	Cardiff & Vale ULHB	OOA jig income (cost accounted for in 25/26)	Surgery	T&O	NR	Income Generation	8	0	8	Month 1		01-Apr-26	Green
116	Cardiff & Vale ULHB	Wet AMD drug product review	Surgery	Ophthalmology	R	Cash-Releasing Saving	400	400	400	Month 1	400	01-Apr-26	Green
117	Cardiff & Vale ULHB	CHFW - Review of Stock Issues	Children and Women	CHFW	NR	Cash-Releasing Saving	90	0	90	In Year		01-Apr-26	Green
118	Cardiff & Vale ULHB	Admin review CHFWS reduction in WTES	Children and Women	CHFW	R	Cash-Releasing Saving	142	0	142	In Year	141.688	01-Apr-26	Green
119	Cardiff & Vale ULHB	Rental of mobile MRI Q3 and Q4 - Swansea Bay	Clinical Diagnostics and Therapeutics	CLINICAL DIAGNOSTICS AND THERAPEUTICS MANAGEMENT	NR	Income Generation	120	0	120	In Year		01-Sep-26	Green
120	Cardiff & Vale ULHB	Biochemistry Annual Leave Purchase 26/27	Clinical Diagnostics and Therapeutics	MBI	NR	Cash-Releasing Saving	12	0	12	In Year	0	01-May-26	Green

ID	Organisation	Scheme / Opportunity Title	Division	Business Unit	Recurrent (R) / Non Recurrent (NR)	Definition	Current Year Annual Plan £'000	Plan FYE (Recurring Schemes only) £'000	Current Year Forecast £'000	Scheme Identified: By Month 1 or In Year (AG only In Year)	Forecast FYE (Recurring Schemes only) £'000	Scheme Start Date	Scheme RAG rating
121	Cardiff & Vale ULHB	Release of HPLC 1260 Service	Clinical Diagnostics and Therapeutics	MBI	NR	Cash-Releasing Saving	6	0	6	In Year	0	01-May-26	Green
122	Cardiff & Vale ULHB	Larger Kit for Assays	Clinical Diagnostics and Therapeutics	MBI	R	Cash-Releasing Saving	7	0	7	In Year	8.805	01-Jul-26	Green
123	Cardiff & Vale ULHB	Stem Cell Planer Maintenance	Clinical Diagnostics and Therapeutics	HAEMATOLOGY	NR	Cash-Releasing Saving	6	0	6	In Year	0	01-May-26	Green
124	Cardiff & Vale ULHB	Reduction in service charge costs	Capital Estates and Facilities	Property	R	Cash-Releasing Saving	15	0	15	In Year	15	01-Apr-26	Green
125	Cardiff & Vale ULHB	Patient clothing costs	Capital Estates and Facilities	Linen	R	Cash-Releasing Saving	50	0	50	In Year	50	01-Apr-26	Green
126	Cardiff & Vale ULHB	Outsourcing of CRI	Capital Estates and Facilities	Security	R	Cash-Releasing Saving	8	0	8	In Year	15	01-Sep-26	Green
127	Cardiff & Vale ULHB	Robot cleaning	Capital Estates and Facilities	Housekeeping	R	Cash-Releasing Saving	25	0	25	In Year	25	01-May-26	Green
128	Cardiff & Vale ULHB	Updated Rookwood savings	Capital Estates and Facilities	Security	R	Cash-Releasing Saving	172	0	172	In Year	172	01-May-26	Green
129	Cardiff & Vale ULHB	Woodland House Security savings	Capital Estates and Facilities	Security	R	Cash-Releasing Saving	12	0	12	In Year	12	01-May-26	Green
130	Cardiff & Vale ULHB	Ustekinumab - Wezenla to Steqeyma - IBD	Medicine	Specialised Medicine	R	Cash-Releasing Saving	100	0	100	In Year	152.582	01-May-26	Green
131	Cardiff & Vale ULHB	Golimumab biosimilar available - Rheum	Medicine	Specialised Medicine	R	Cash-Releasing Saving	158	0	158	In Year	177.61	01-May-26	Green
132	Cardiff & Vale ULHB	Golimumab biosimilar available - IBD	Medicine	Specialised Medicine	R	Cash-Releasing Saving	8	0	8	In Year	9.788	01-May-26	Green
133	Cardiff & Vale ULHB	Repatriation of LSU patient to local services (ME)	Mental Health	Continuing Healthcare	R	Cash-Releasing Saving	141	0	141	In Year	140.94	01-Jul-26	Green
134	Cardiff & Vale ULHB	Lived Experience / Peer Support Reshaping	Mental Health	Clinical Board Management	R	Cash-Releasing Saving	32	0	32	In Year	32	18-May-26	Green
135	Cardiff & Vale ULHB	GMS Sustainability - Notes Storage	Primary, Community and Intermediate Care	Primary Care	R	Cash-Releasing Saving	20	0	20	In Year	40	01-Oct-26	Green
136	Cardiff & Vale ULHB	A&C skillmix (8a to B7)	Surgery	T&O	NR	Cash-Releasing Saving	5	0	5	In Year	0	01-Jun-26	Green
137	Cardiff & Vale ULHB	Private Patient Income	Surgery	T&O	R	Income Generation	5	0	0	In Year		01-Jul-26	Amber
138	Cardiff & Vale ULHB	Private Patient Income	Surgery	Urology	R	Income Generation	50	0	50	In Year	50	01-May-26	Green
139	Cardiff & Vale ULHB	TACU closure	Surgery	T&O	NR	Cash-Releasing Saving	40	0	40	In Year		01-May-26	Green
140	Cardiff & Vale ULHB	Neurosciences Advanced Therapies Research Programme	Surgery	Theatres, Anaesthetics, SSSU & Sterilisation Services	NR	Income Generation	50	0	50	In Year		01-Jul-26	Green
141	Cardiff & Vale ULHB	Historic Velindre Brachytherapy Service Support SLA Uplift	Surgery	Theatres, Anaesthetics, SSSU & Sterilisation Services	R	Income Generation	29	0	29	In Year	29	01-May-26	Green
142	Cardiff & Vale ULHB	Additional new supplier for Spinal Monitoring savings	Surgery	T&O	R	Cash-Releasing Saving	15	0	15	In Year	18	01-Jun-26	Green
143	Cardiff & Vale ULHB	SAP Patients IPFR Income	Surgery	General Surgery	R	Income Generation	55	0	55	In Year	55	01-May-26	Green
144	Cardiff & Vale ULHB	CYPFHS - Repatriation of CCNS	Children and Women	CYPFHS	R	Cash-Releasing Saving	40	40	40	In Year	40	01-Jun-26	Green
145	Cardiff & Vale ULHB	CHC/CCNS growth avoidance	Children and Women	CYPFHS	R	Cash-Releasing Saving	100	100	100	In Year	100	01-Jul-26	Green
146	Cardiff & Vale ULHB	Room Hire Saving	Children and Women	CYPFHS	R	Cash-Releasing Saving	11	12	12	In Year	12	01-Jul-26	Green
147	Cardiff & Vale ULHB	Further targetted high cost LD package review	Children and Women	CAW MGT	R	Cash-Releasing Saving	1,083	1,300	518	In Year	508	01-Jul-26	Green
148	Cardiff & Vale ULHB	CAW MGT - Annual Leave Purchase	Children and Women	CAW MGT	NR	Cash-Releasing Saving	5	0	4	In Year		01-Jun-26	Green
149	Cardiff & Vale ULHB	O&G - Band 7 GOPD Remodel	Children and Women	O&G	NR	Cash-Releasing Saving	82	0	70	In Year		01-Jun-26	Green
150	Cardiff & Vale ULHB	O&G - Reduction in BPAS Usage	Children and Women	O&G	R	Cash-Releasing Saving	35	30	30	In Year	30	01-Jun-26	Green

ID	Organisation	Scheme / Opportunity Title	Division	Business Unit	Recurrent (R) / Non Recurrent (NR)	Definition	Current Year Annual Plan £'000	Plan FYE (Recurring Schemes only) £'000	Current Year Forecast £'000	Scheme Identified: By Month 1 or In Year (AG only In Year)	Forecast FYE (Recurring Schemes only) £'000	Scheme Start Date	Scheme RAG rating
151	Cardiff & Vale ULHB	Rebaslining of 3rd patry suppliers Haem MSC	Clinical Diagnostics and Therapeutics	HAEMATOLOGY	R	Cash-Releasing Saving	52	52	39	In Year	52	01-Jul-26	Green
152	Cardiff & Vale ULHB	Batch ordering/carriage consolidation	Clinical Diagnostics and Therapeutics	CLINICAL DIAGNOSTICS AND THERAPEUTICS MANAGEMENT	R	Cash-Releasing Saving	52	52	52	In Year	51.622	01-Jul-26	Green
153	Cardiff & Vale ULHB	Conversion of Overtime to Bank	Clinical Diagnostics and Therapeutics	CLINICAL DIAGNOSTICS AND THERAPEUTICS MANAGEMENT	R	Cash-Releasing Saving	54	54	54	In Year	54	01-Jun-26	Green
154	Cardiff & Vale ULHB	UHL Pharmacy Tech savings	Clinical Diagnostics and Therapeutics	PHARMACY & MEDICINE'S MANAGEMENT GENERAL	R	Cash-Releasing Saving	28	33	28	In Year	33.276	01-Jun-26	Green
155	Cardiff & Vale ULHB	Recurrent off-contract income	Clinical Diagnostics and Therapeutics	PHARMACY & MEDICINE'S MANAGEMENT GENERAL	R	Income Generation	20	20	20	In Year	20	01-Jun-26	Green
156	Cardiff & Vale ULHB	Non Cat to Cat (Synnovis Element)	Clinical Diagnostics and Therapeutics	CLINICAL DIAGNOSTICS AND THERAPEUTICS MANAGEMENT	R	Cash-Releasing Saving	50	112	50	In Year	112	01-Jul-26	Green
157	Cardiff & Vale ULHB	Navigational Bronchoscopy Band 6 0.2	Clinical Diagnostics and Therapeutics	RADIOLOGY	NR	Cash-Releasing Saving	5	0	5	In Year	0	01-Oct-26	Green
158	Cardiff & Vale ULHB	CUBRIC B6 - RDA	Clinical Diagnostics and Therapeutics	RADIOLOGY	NR	Cash-Releasing Saving	3	0	32	In Year	0	01-Jul-26	Green
159	Cardiff & Vale ULHB	Mechanical Engineering - 0.22 band 6 vacancy	Clinical Diagnostics and Therapeutics	MEDICAL PHYSICS, CLINICAL ENGINEERING & MEDICAL ILLUSTRATION	R	Cash-Releasing Saving	13	11	11	In Year	11	01-Jul-26	Green
160	Cardiff & Vale ULHB	Shandon Diagnostics Contract Reduction	Clinical Diagnostics and Therapeutics	CELLULAR PATHOLOGY	R	Cash-Releasing Saving	12	15	12	In Year	14.65975	01-Jul-26	Green
161	Cardiff & Vale ULHB	Closure of PSU Nitritex contract	Clinical Diagnostics and Therapeutics	PHARMACY & MEDICINE'S MANAGEMENT GENERAL	R	Cash-Releasing Saving	15	25	17	In Year	25	01-Aug-26	Green
162	Cardiff & Vale ULHB	Closure of PSU Pharmagraph contract	Clinical Diagnostics and Therapeutics	PHARMACY & MEDICINE'S MANAGEMENT GENERAL	R	Cash-Releasing Saving	5	9	6	In Year	9	01-Aug-26	Green
163	Cardiff & Vale ULHB	Closure of PSU Envair Contract	Clinical Diagnostics and Therapeutics	PHARMACY & MEDICINE'S MANAGEMENT GENERAL	R	Cash-Releasing Saving	2	4	3	In Year	4	01-Aug-26	Green
164	Cardiff & Vale ULHB	Reduced Outsourcing	Clinical Diagnostics and Therapeutics	CLINICAL DIAGNOSTICS AND THERAPEUTICS MANAGEMENT	R	Cash-Releasing Saving	417	500	500	In Year	500	01-Oct-26	Green
165	Cardiff & Vale ULHB	Woodland House Energy savings	Capital Estates and Facilities	Energy	R	Cash-Releasing Saving	18	20	18	In Year	20	01-Jun-26	Green
166	Cardiff & Vale ULHB	Rates Rebates	Capital Estates and Facilities	Property	R	Cash-Releasing Saving	200	200	200	In Year	200	01-Jul-26	Green
167	Cardiff & Vale ULHB	Disestablish SSET Band 8a	Capital Estates and Facilities	Management	R	Cash-Releasing Saving	75	75	69	In Year	75	01-May-26	Green
168	Cardiff & Vale ULHB	DIFFS Helipad System	Capital Estates and Facilities	Portering	R	Cash-Releasing Saving	54	63	50	In Year	63	01-May-26	Green
169	Cardiff & Vale ULHB	Rookwood decomissioning	Capital Estates and Facilities	Energy	R	Cash-Releasing Saving	35	84	42	In Year	84	01-Oct-26	Green
170	Cardiff & Vale ULHB	Enhancements for Night Workers	Capital Estates and Facilities	Housekeeping	R	Cash-Releasing Saving	44	38	38	In Year	38	01-Apr-26	Green
171	Cardiff & Vale ULHB	CONSULTANT ROLE RE-EVALUATION (AG) CONSULTANT	Corporate Executives	Public Health	R	Cash-Releasing Saving	20	29	22	In Year	29	01-Jul-26	Green
172	Cardiff & Vale ULHB	CONSULTANT ROLE RE-EVALUATION (CC) BAND 9	Corporate Executives	Public Health	R	Cash-Releasing Saving	22	33	25	In Year	33	01-Jul-26	Green
173	Cardiff & Vale ULHB	CANCELLATION OF SYSTEM CONTRACT	Corporate Executives	Chief executive officer	R	Cash-Releasing Saving	8	7	7	In Year	7	01-Jun-26	Green
174	Cardiff & Vale ULHB	TRANSLATION COSTS	Corporate Executives	Chief executive officer	R	Cash-Releasing Saving	18	15	15	In Year	15	01-Jun-26	Green
175	Cardiff & Vale ULHB	OCP BAND 8A	Corporate Executives	Digital	R	Cash-Releasing Saving	85	73	73	In Year	73	01-Jun-26	Green
176	Cardiff & Vale ULHB	SITE/OPAT RESTRUCTURE 3% PAY SAVINGS	Corporate Executives	Chief Operating Officer	R	Cash-Releasing Saving	45	107	54	In Year	107	01-Oct-26	Green
177	Cardiff & Vale ULHB	SITE/OPAT NON PAY BUDGET RESET	Corporate Executives	Chief Operating Officer	R	Cash-Releasing Saving	34	50	38	In Year	50	01-Jul-26	Green
178	Cardiff & Vale ULHB	CANCER ADMIN RESTRUCTURE 2% REDUCTION	Corporate Executives	Chief Operating Officer	R	Cash-Releasing Saving	5	30	8	In Year	30	01-Jan-27	Amber
179	Cardiff & Vale ULHB	COO STAFF CHANGES	Corporate Executives	Chief Operating Officer	R	Cash-Releasing Saving	33	79	40	In Year	79	01-Oct-26	Green
180	Cardiff & Vale ULHB	British Red Cross	Medicine	Emergency Medicine	R	Cash-Releasing Saving	22	29	29	In Year	28.809	01-Dec-26	Green

ID	Organisation	Scheme / Opportunity Title	Division	Business Unit	Recurrent (R) / Non Recurrent (NR)	Definition	Current Year Annual Plan £'000	Plan FYE (Recurring Schemes only) £'000	Current Year Forecast £'000	Scheme Identified: By Month 1 or In Year (AG only In Year)	Forecast FYE (Recurring Schemes only) £'000	Scheme Start Date	Scheme RAG rating
181	Cardiff & Vale ULHB	Establishment Review	Medicine	All Areas	R	Cash-Releasing Saving	117	323	132	In Year	323	01-Oct-26	Green
182	Cardiff & Vale ULHB	Vedolizumab - price reduction	Medicine	Specialised Medicine	R	Cash-Releasing Saving	440	490	490	In Year	490	01-Jul-26	Green
183	Cardiff & Vale ULHB	Nintedanib further price reduction - Respiratory	Medicine	Specialised Medicine	R	Cash-Releasing Saving	533	600	666	In Year	600	01-Jul-26	Green
184	Cardiff & Vale ULHB	Expansion of MIND partnership, through increased beds and extended hours	Mental Health	Continuing Healthcare	R	Cash-Releasing Saving	198	198	198	In Year	198	01-Mar-27	Green
185	Cardiff & Vale ULHB	IRIS (domestic violence) SLA. Reduce activity/cease	Primary, Community and Intermediate Care	Primary Care	R	Cash-Releasing Saving	29	0	35	In Year	70	01-Jul-26	Green
186	Cardiff & Vale ULHB	Linagliptin and saxagliptin to sitagliptin 100mg	Primary, Community and Intermediate Care	Medicines Management	R	Cash-Releasing Saving	276	663	331	In Year	663	01-Oct-26	Green
187	Cardiff & Vale ULHB	JES Bulk Purchases	Primary, Community and Intermediate Care	Community Care Management	NR	Cash-Releasing Saving	500	0	500	In Year		01-Jul-26	Green
188	Cardiff & Vale ULHB	Palliative Care SLA Management	Primary, Community and Intermediate Care	Community Care Management	NR	Cash-Releasing Saving	200	0	200	In Year		01-Jul-26	Green
189	Cardiff & Vale ULHB	DoSH Pathology tests	Primary, Community and Intermediate Care	Health Protection & Health Inclusion	R	Cash-Releasing Saving	12	10	10	In Year	10	01-Jun-26	Green
190	Cardiff & Vale ULHB	Omulizumab	Specialist Services	Immunology	R	Cash-Releasing Saving	60	103	69	In Year	103	01-Aug-26	Green
191	Cardiff & Vale ULHB	30% reduction in agency	Specialist Services	Corporate	NR	Cash-Releasing Saving	80	0	80	In Year		01-Aug-26	Green
192	Cardiff & Vale ULHB	10% reduction in bank	Specialist Services	Corporate	R	Cash-Releasing Saving	219	375	250	In Year	375	01-Aug-26	Green
193	Cardiff & Vale ULHB	BPAS Income Generation	Surgery	T&O	NR	Income Generation	88	0	88	In Year	0	01-Jun-26	Green
194	Cardiff & Vale ULHB	Lapropscopic review - supplier proposal J&J, Medtronic and GenMed	Surgery	Theatres, Anaesthetics, SSSU & Sterilisation Services	R	Cash-Releasing Saving	130	0	156	In Year	156	01-Oct-26	Green
195	Cardiff & Vale ULHB	TACU closure	Surgery	T&O	NR	Cash-Releasing Saving	20	0	20	In Year		01-Jul-26	Green
196	Cardiff & Vale ULHB	Admin & Clerical Band 6 Vacancy	Surgery	Urology	NR	Cash-Releasing Saving	13	0	10	In Year		01-Jun-26	Green
197	Cardiff & Vale ULHB	Temporary Reduction in 1 Consultant session (Apr-Aug)	Surgery	Urology	NR	Cash-Releasing Saving	12	0	8	In Year		01-May-26	Green
198	Cardiff & Vale ULHB	CTM IR SLA Income	Surgery	General Surgery	NR	Income Generation	83	0	87	In Year		01-Jun-26	Green
199	Cardiff & Vale ULHB	Temp closure of 9 beds on B6 (6 months extension)	Surgery	ENT	R	Cash-Releasing Saving	88	0	105	In Year		01-Oct-26	Green
200	Cardiff & Vale ULHB	IVT Patent Expiry	Surgery	Ophthalmology	NR	Cash-Releasing Saving	650	0	650	In Year		01-Jun-26	Green
201	Cardiff & Vale ULHB	Reduction Registered Nursing additional basic hours	Children and Women	O&G	R	Cash-Releasing Saving	60	0	60	In Year	60	01-Jun-26	Green
202	Cardiff & Vale ULHB	Reduction of 10% on Unregistered Nursing additional basic hours	Children and Women	O&G	R	Cash-Releasing Saving	50	0	50	In Year	50	01-Jun-26	Green
203	Cardiff & Vale ULHB	Review uncoded activity	Children and Women	CHFW	R	Cash-Releasing Saving	100	0	100	In Year	100	01-Sep-26	Green
204	Cardiff & Vale ULHB	CHFW - Student Streamliner Variable Pay Reduction	Children and Women	CHFW	R	Cash-Releasing Saving	182	0	182	In Year	364	08-Nov-26	Green
205	Cardiff & Vale ULHB	O&G - Closure of 4 Beds - Ward B2	Children and Women	O&G	R	Cash-Releasing Saving	210	0	210	In Year	315	01-Sep-26	Green
206	Cardiff & Vale ULHB	CHC - Reduction to Uplifts	Children and Women	CYPFHS	R	Cash-Releasing Saving	139	0	139	In Year	139.403	01-Jul-26	Green
207	Cardiff & Vale ULHB	R&D income	Clinical Diagnostics and Therapeutics	PHARMACY & MEDICINE'S MANAGEMENT GENERAL	NR	Income Generation	19	0	19	In Year	0	01-Oct-26	Green
208	Cardiff & Vale ULHB	Head of Production savings	Clinical Diagnostics and Therapeutics	ST MARY'S PHARMACEUTICAL UNIT	R	Cash-Releasing Saving	19	0	19	In Year	24	01-Jul-26	Green
209	Cardiff & Vale ULHB	SMPU B7 saving	Clinical Diagnostics and Therapeutics	ST MARY'S PHARMACEUTICAL UNIT	R	Cash-Releasing Saving	10	0	10	In Year	13	01-Jul-26	Green
210	Cardiff & Vale ULHB	Review and reallocation of central pay budgets to release savings as part of the financial recovery plan.	Corporate	Corporate	R	Cash-Releasing Saving	1,200	0	1,200	In Year	1205	01-Jul-26	Green

ID	Organisation	Scheme / Opportunity Title	Division	Business Unit	Recurrent (R) / Non Recurrent (NR)	Definition	Current Year Annual Plan £'000	Plan FYE (Recurring Schemes only) £'000	Current Year Forecast £'000	Scheme Identified: By Month 1 or In Year (AG only In Year)	Forecast FYE (Recurring Schemes only) £'000	Scheme Start Date	Scheme RAG rating
211	Cardiff & Vale ULHB	Efficiencies from change temporary Acute model	Medicine	All Areas	NR	Cash-Releasing Saving	239	0	563	In Year	0	01-Oct-26	Amber
212	Cardiff & Vale ULHB	CHC uplift plan	Mental Health	Continuing Healthcare	R	Cash-Releasing Saving	45	0	45	In Year	45	01-Jul-26	Green
213	Cardiff & Vale ULHB	Package uplifts limited to 1.11%	Primary, Community and Intermediate Care	CHC	R	Cash-Releasing Saving	297	0	297	In Year	297.495	01-Jul-26	Green
214	Cardiff & Vale ULHB	GP Business Rates rebates	Primary, Community and Intermediate Care	Primary Care	NR	Cash-Releasing Saving	80	0	80	In Year		01-Oct-26	Green
215	Cardiff & Vale ULHB	Review PACU medical workforce model	Specialist Services	Critical Care	R	Cash-Releasing Saving	70	0	70	In Year	122	01-Sep-26	Green
216	Cardiff & Vale ULHB	Review & reduce bed base (reduce outliers) on B4	Specialist Services	Neurosciences	R	Cash-Releasing Saving	64	0	64	In Year	81	01-Aug-26	Green
217	Cardiff & Vale ULHB	Review MS prescribing pathways	Specialist Services	Corporate	R	Cash-Releasing Saving	60	0	60	In Year	80	01-Aug-26	Green
218	Cardiff & Vale ULHB	Alternative Vascath supplier	Specialist Services	Critical care	R	Cash-Releasing Saving	9	0	9	In Year	12.607	01-Jul-26	Green
219	Cardiff & Vale ULHB	Alternative Arterial Blood Sampler supplier	Specialist Services	Critical care	R	Cash-Releasing Saving	24	0	24	In Year	31.426	01-Jul-26	Green
220	Cardiff & Vale ULHB	Video Laryngoscope Blades FOC	Specialist Services	Critical care	NR	Cash-Releasing Saving	13	0	13	In Year	0	01-Jul-26	Green
221	Cardiff & Vale ULHB	Central Line Placement Packs product switch	Specialist Services	Critical care	R	Cash-Releasing Saving	3	0	3	In Year	4.147	01-Jul-26	Green
222	Cardiff & Vale ULHB	Cease usage of Cannulation Packs	Specialist Services	Critical care	R	Cash-Releasing Saving	2	0	2	In Year	2.478	01-Jul-26	Green
223	Cardiff & Vale ULHB	Cannulation Dressings product switch	Specialist Services	Critical care	R	Cash-Releasing Saving	2	0	2	In Year	3.734	01-Aug-26	Green
224	Cardiff & Vale ULHB	Trilogy 4 Myeloma Trial	Specialist Services	Haematology	NR	Cash-Releasing Saving	180	0	180	In Year		01-Jul-26	Green
225	Cardiff & Vale ULHB	Cessation of plastics clinic	Specialist Services	MTC	R	Cash-Releasing Saving	13	0	13	In Year	25	01-Oct-26	Green
226	Cardiff & Vale ULHB	Eculizumab price reduction	Specialist Services	N&T	R	Cash-Releasing Saving	127	0	127	In Year	169	01-Jul-26	Green
227	Cardiff & Vale ULHB	Extension of MTC commitment agreement with J&J Depuy Synthes	Surgery	Theatres, Anaesthetics, SSSU & Sterilisation Services	R	Cash-Releasing Saving	20	30	20	In Year	30	01-Aug-26	Green
228	Cardiff & Vale ULHB	O&G - Translation Recharges	Children and Women	O&G	R	Cash-Releasing Saving	50	90	50	In Year	90	01-Jul-26	Green
229	Cardiff & Vale ULHB	Further Admin Review Reduction in 0.8wte	Children and Women	CHFW	R	Cash-Releasing Saving	16	16	16	In Year	16.333	01-Sep-26	Green
230	Cardiff & Vale ULHB	SLT Actions - Vacancy Hold M1-M5	Children and Women	CAW MGT	NR	Cash-Releasing Saving	235	0	315	In Year		01-Sep-26	Green
231	Cardiff & Vale ULHB	Aviado Bio - R&D Commercial Trial	Clinical Diagnostics and Therapeutics	RADIOLOGY	NR	Income Generation	80	0	80	In Year	0	01-Aug-26	Green
232	Cardiff & Vale ULHB	Skill Mix Band 7	Clinical Diagnostics and Therapeutics	PODIATRY	R	Cash-Releasing Saving	58	58	58	In Year	57.681	01-Jul-26	Green
233	Cardiff & Vale ULHB	Non Cat to Cat (Logistics Consolidation Project - City Sprint) - component of Scheme 80	Clinical Diagnostics and Therapeutics	MBI	R	Cash-Releasing Saving	3	5	3	In Year	4.869	01-Sep-26	Green
234	Cardiff & Vale ULHB	Non Cat to Cat (Logistics Consolidation Project - City Sprint) - component of Scheme 80	Clinical Diagnostics and Therapeutics	CELLULAR PATHOLOGY	R	Cash-Releasing Saving	3	5	3	In Year	4.7	01-Sep-26	Green
235	Cardiff & Vale ULHB	Vacancy Savings August	Medicine	All Areas	NR	Cash-Releasing Saving	33	0	33	In Year		01-Sep-26	Green
236	Cardiff & Vale ULHB	Stable and Severe Service Closure and Resource Redeployment Stable - Headcount Reduction -NB 2A471 0.8 WTE	Mental Health	Adult Mental Health	R	Cash-Releasing Saving	30	60	30	In Year	60	01-Oct-26	Green
237	Cardiff & Vale ULHB	Neuropsychaitry Block Switch	Mental Health	Mental Health Older Persons	NR	Cash-Releasing Saving	475	0	475	In Year		01-Sep-26	Green
238	Cardiff & Vale ULHB	Fluoxetine 10mg tabs to caps	Primary, Community and Intermediate Care	Medicines Management	R	Cash-Releasing Saving	3	10	3	In Year	10	01-Jan-27	Amber
239	Cardiff & Vale ULHB	metformin 1g/5mL oral solution to 2x500mg/5mL	Primary, Community and Intermediate Care	Medicines Management	R	Cash-Releasing Saving	4	15	4	In Year	15	01-Jan-27	Amber

ID	Organisation	Scheme / Opportunity Title	Division	Business Unit	Recurrent (R) / Non Recurrent (NR)	Definition	Current Year Annual Plan £'000	Plan FYE (Recurring Schemes only) £'000	Current Year Forecast £'000	Scheme Identified: By Month 1 or In Year (AG only In Year)	Forecast FYE (Recurring Schemes only) £'000	Scheme Start Date	Scheme RAG rating
240	Cardiff & Vale ULHB	EP Framework - J&J	Specialist Services	Cardiothoracic	NR	Cash-Releasing Saving	7	0	7	In Year		01-Sep-26	Green
241	Cardiff & Vale ULHB	Plasma exchange - hereditary Anaemias	Specialist Services	Haematology	R	Cash-Releasing Saving	60	60	60	In Year	60	01-Jan-27	Amber
242	Cardiff & Vale ULHB	Cath lab rationalisation of consumables	Specialist Services	Cardiothoracic	R	Cash-Releasing Saving	60	60	60	In Year	60	01-Oct-26	Amber
243	Cardiff & Vale ULHB	IVT Patent Expiry	Surgery	Ophthalmology	NR	Cash-Releasing Saving	-91	0	79	In Year		01-Jun-26	Green
244	Cardiff & Vale ULHB	Private Patient Income	Surgery	Urology	R	Income Generation	20	20	20	In Year	20	01-Aug-26	Green
245	Cardiff & Vale ULHB	SLT ACTIONS - VACANCY HOLD	Surgery	Ophthalmology	NR	Cash-Releasing Saving	9	0	9	In Year		01-Aug-26	Green
246	Cardiff & Vale ULHB	SLT ACTIONS - VACANCY HOLD	Surgery	Dental	NR	Cash-Releasing Saving	23	0	23	In Year		01-Aug-26	Green
247	Cardiff & Vale ULHB	SLT ACTIONS - VACANCY HOLD	Surgery	ENT	NR	Cash-Releasing Saving	2	0	2	In Year		01-Aug-26	Green
248	Cardiff & Vale ULHB	SLT ACTIONS - VACANCY HOLD	Surgery	General Surgery	NR	Cash-Releasing Saving	3	0	3	In Year		01-Aug-26	Green
249	Cardiff & Vale ULHB	SLT ACTIONS - VACANCY HOLD	Surgery	Theatres, Anaesthetics, SSSU & Sterilisation Services	NR	Cash-Releasing Saving	6	0	6	In Year		01-Aug-26	Green
250	Cardiff & Vale ULHB	RSV reduce allocation deliver on previous standards	Children and Women	CHFW	R	Cash-Releasing Saving	100	100	100	In Year	100	01-Nov-26	Amber
251	Cardiff & Vale ULHB	O&G - Midwifery Study Leave Reduction To 2 Days (Backfill saving)	Children and Women	O&G	R	Cash-Releasing Saving	35	35	35	In Year	35	01-Nov-26	Amber
252	Cardiff & Vale ULHB	Non Cat to Cat (Neuro Medical Equipment Contracting Programme)	Clinical Diagnostics and Therapeutics	CLINICAL DIAGNOSTICS AND THERAPEUTICS MANAGEMENT	R	Cash-Releasing Saving	26	45	26	In Year	44.72	01-Oct-26	Amber
253	Cardiff & Vale ULHB	Velindre CAT Clinic Income	Clinical Diagnostics and Therapeutics	PHARMACY & MEDICINE'S MANAGEMENT GENERAL	NR	Income Generation	8	0	0	In Year		01-Sep-26	Green
254	Cardiff & Vale ULHB	Reduction in radiographer hours & skill mix	Clinical Diagnostics and Therapeutics	RADIOLOGY	R	Cash-Releasing Saving	8	0	0	In Year		01-Sep-26	Green
255	Cardiff & Vale ULHB	B5 to B4 Radiographer skill mix	Clinical Diagnostics and Therapeutics	RADIOLOGY	R	Cash-Releasing Saving	2	0	0	In Year		01-Sep-26	Green
256	Cardiff & Vale ULHB	Vacancy Control	Medicine	All Areas	NR	Cash-Releasing Saving	315	0	315	In Year		01-Sep-26	Green
257	Cardiff & Vale ULHB	Bank Reduction 10%	Medicine	All Areas	NR	Cash-Releasing Saving	6	0	6	In Year		01-Sep-26	Green
258	Cardiff & Vale ULHB	Agency Reduction 30%	Medicine	All Areas	NR	Cash-Releasing Saving	12	0	12	In Year		01-Sep-26	Green
259	Cardiff & Vale ULHB	Daisy redbox system	Primary, Community and Intermediate Care	Health Protection & Health Inclusion	R	Cash-Releasing Saving	6	6	6	In Year	6	01-Apr-26	Green
260	Cardiff & Vale ULHB	Neighbourhood Nursing efficiencies	Primary, Community and Intermediate Care	Community Care Management	NR	Cash-Releasing Saving	70	0	70	In Year		01-Aug-26	Green
261	Cardiff & Vale ULHB	Propofol change of vial strength	Specialist Services	Critical Care	R	Cash-Releasing Saving	5	11	5	In Year	11	01-Nov-26	Green
262	Cardiff & Vale ULHB	Pre made noradrenaline vials / glucose split	Specialist Services	Critical Care	R	Cash-Releasing Saving	3	5	3	In Year	5.4	01-Sep-26	Green
263	Cardiff & Vale ULHB	TAVI Growth Investment	Specialist Services	Cardiothoracic	R	Cash-Releasing Saving	273	273	273	In Year	273.45	01-Nov-26	Green
264	Cardiff & Vale ULHB	Private Patient Income stretch target	Surgery	Urology	R	Income Generation	20	20	20	In Year	20	01-Sep-26	Green
265	Cardiff & Vale ULHB	Urology rota compliance banding reduction	Surgery	Urology	NR	Cash-Releasing Saving	177	0	177	In Year		01-Sep-26	Green
266	Cardiff & Vale ULHB	Ephedrine pre filled syringes swap	Surgery	Theatres, Anaesthetics, SSSU & Sterilisation Services	R	Cash-Releasing Saving	30	52	30	In Year	52	01-Sep-26	Green
267	Cardiff & Vale ULHB	Reduction in medical locum expenditure	Surgery	T&O	R	Cash-Releasing Saving	18	30	18	In Year	30	01-Sep-26	Green
268	Cardiff & Vale ULHB	Reduction in drug expenditure	Surgery	T&O	R	Cash-Releasing Saving	12	20	12	In Year	20	01-Sep-26	Green
269	Cardiff & Vale ULHB	Disestablish Neurophysiologist vacancy	Surgery	T&O	R	Cash-Releasing Saving	12	20	12	In Year	20	01-Sep-26	Green
270	Cardiff & Vale ULHB	Probe Tube Swap	Surgery	Audiology	R	Cash-Releasing Saving	1	1	1	In Year	1	01-Oct-26	Green
271	Cardiff & Vale ULHB	STP 1 WTE Backfill accepted at 0.89 WTE for 3 years	Surgery	Audiology	NR	Cash-Releasing Saving	9	0	9	In Year		12-Oct-26	Green
272	Cardiff & Vale ULHB	Parental Leave weeks 27-39	Surgery	Audiology	NR	Cash-Releasing Saving	10	0	10	In Year		26-Oct-26	Green
273	Cardiff & Vale ULHB	CESR trainee programme stopped	Surgery	Theatres, Anaesthetics, SSSU & Sterilisation Services	R	Cash-Releasing Saving	0	0	0	In Year	130	01-Apr-27	Green
274	Cardiff & Vale ULHB	Paediatric consultants banding supplement change from 3 to 2	Surgery	Theatres, Anaesthetics, SSSU & Sterilisation Services	R	Cash-Releasing Saving	0	47	0	In Year	47	01-Apr-27	Green
275	Cardiff & Vale ULHB	Reduction in sendout tests to external parties	AWGS	LAB GENETICS	NR	Cash-Releasing Saving	369	0	369	In Year		01-Sep-26	Green
276	Cardiff & Vale ULHB	Consumable test kit price reductions	AWGS	LAB GENETICS	NR	Cash-Releasing Saving	200	0	200	In Year		01-Sep-26	Green
277	Cardiff & Vale ULHB	Good Receipted Not Invoiced - GRNI write off	Corporate	Corporate	NR	Accountancy Gains	162	0	162	In Year		01-Sep-26	Green

Report Title:	Regional Partnership Board Funding Stream Q2 reports 2026-27		Agenda Item no.		4.2
Meeting:	Finance and Performance Committee	Public	X	Meeting Date:	18.11.2026
		Private			
Lead Executive:	Executive Director of Strategic Planning				
Report Author:	Head of Partnerships and Assurance				

ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

None.

ADVISE *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

The Regional Integration Fund was scheduled to complete in March 2027. This constituted a risk of £7.5m for the UHB as well as financial risks to other partners and a risk to the viability of key community services as a whole.

We have now received assurance from Welsh Government that RIF funding will be continued into the new financial year. However, work is underway to determine the detailed requirements for the future fund and as such all partner organisations are maintaining a holding position until this becomes clear.

ASSURE *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

The RPB has delegated responsibility for the assurance and performance management of its revenue funding streams to the Strategic Leadership Group (SLG). SLG considered a high-level overview of the emerging financial and performance status provided within the reports for each funding stream.

Following this review, the SLG approved all reports for submission to Welsh Government. These were ratified by the Regional Partnership Board at its meeting in November 2026.

Based upon the recommendations from operational colleagues across the partnership, the Strategic Leadership Group and Regional Partnership Board has agreed the use of alternative funding proposals to manage the forecast underspend in line with RPB priorities. These were ratified by the RPB in November 2026.

Board/Committee Response Required ***(please select only one)***
To confirm the action Members are being asked to take considering the AAA Framework

Assurance		**Approval**		**Information /Noting**	X

Recommendations
Recommendations should be clear, actionable, and aligned to the AAA summary above.

The Committee are requested to note for information:
- the Q2 report for RPB performance and funding in 2026-27.

- the financial position at Q2.
- the assurance of ongoing funding but the need to maintain a holding position until the agreement of future requirements guidance.

Governance Route *(please list all other Committee/Groups this report has been to)*	
***Where** it's been:*	Strategic Leadership Group and Regional Partnership Board
***When** it went:*	27.10.26 and 03.11.26
***What** decision was made:*	*Approved.*

Main Report

Regional Partnership Board Funding Stream Q2 reports 2026-27

The Cardiff and Vale of Glamorgan Regional Partnership Board (RPB) was established in response to requirements of the Social Services and Well-being (Wales) Act 2014. Its purpose is to manage and develop services to secure better joint working between local health boards, local authorities and the third sector; and to ensure effective services, care and support that best meet the needs of our population. Cardiff and Vale UHB plays the role of 'banker' for RPB funding streams on behalf of the region.

In 2026-27, the Regional Partnership Board manages the following funding streams on behalf of the region:

- Regional Integration Fund (RIF) (£19,290k)
- Short Breaks for Unpaid Carers (£172k)
- Innovation Working at Scale (£250k)
- IRCF (Capital Fund) Revenue (£450k)
- **Total: £20,163k.**

A full description of each fund together with the Q2 reports which have been prepared in line with Welsh Government expectations are accessible via this hyperlink to the private page of the Cardiff and Vale RPB website.

A high-level overview of the performance status provided within the reports for each funding stream and the overall Joint Area Plan commitments is attached as ***Appendix 1.*** In addition to the Welsh Government reports, the RPB team have also prepared a set of Dashboards for local information and assurance. These contain particular information relating to the financial allocations by partner for each element of the RIF and are available on the same webpage noted above.

Financial Plans for 2026-27

Welsh Government have allocated a range of funding streams to the RPB for use in 2026-27. Overall allocations along with the anticipated expenditure by partner and programme are outlined below.

Funding Source	Source Total	Combined Total	Anticipated Partnership Expenditure			Total Expenditure
			UHB	Cardiff LA	Vale LA	
	£	£	£	£	£	£
RIF Infrastructure	701,186	790,726	750,726	20,000	20,000	**790,726**
RIF agreed over-allocation to support RIF Infrastructure	*44,540*					
RIF ICCS - Social Value	45,000					
RIF ICCS	8,960,375	8,960,375	2,172,975	5,173,785	1,613,615	**8,960,375**
RIF Starting Well - emPower	4,125,354	4,125,354	1,155,779	2,131,549	838,026	**4,125,354**
RIF Starting Well - Complex Health & LD	820,328	820,328	487,079	174,938	158,310	**820,328**
RIF Learning Disablities	1,774,484	1,870,170	256,851	1,082,548	530,771	**1,870,170**
RIF agreed over-allocation to support strategic development	*95,686*					
RIF Unpaid Carers	479,042	650,985	428,985	222,000	0	**650,985**
Short Breaks Fund	171,943					
RIF IAS (Ringfenced)	397,728	397,728	397,728	0	0	**397,728**
RIF Dementia (Ringfenced)	1,600,000	1,827,591	1,328,018	231,573	268,000	**1,827,591**
RIF ICCS (Ty Dyfan)	227,591					
Capital Revenue (IRCF)	450,000	450,000	93,250	289,435	67,315	**450,000**
Innovation Working at Scale (RIC)	250,000	409,582	393,582	0	16,000	**409,582**
RIF ICCS Crisis reponse	75,768					
RIF Infrastructure (DCR resource)	48,814					
RIF Digital	35,000					
TOTAL WG Allocation	**20,162,613**					
Total Over-commitment*	**140,226**					
TOTAL	**20,302,839**	**20,302,839**	**7,464,973**	**9,325,828**	**3,512,038**	**20,302,839**

The Partner expenditure profiles present a variance against allocation which is not considered a material risk across partner organisations and is expected to be managed via slippage through the financial year.

All funding streams have structures in place to ensure effective management with overall assurance provided via the Strategic Leadership Group. All partners have made an explicit commitment that any consequent end of year overspend will need to be managed locally by individual partners.

In addition, guidance has been developed to support overall management of the funding streams which includes:

- Senior Responsible Owner responsibilities, including the introduction of Lead and Associate SROs for projects where funding spans across numerous partners
- Budget and performance management guidance and the role of the RPB team in supporting these functions
- Reporting timelines
- A 'Who's who' of all SROs and financial support leads across the programmes.

Strict arrangements are in place to ensure that all over commitments are brought back in line with overall allocations by the end of the financial year.

As of Quarter 2, RIF expenditure showed the following underspend position:

Actuals 26/27 - Partner Expenditure Plan	Programme Expenditure 2026/27 £						
Programme	Allocation £	UHB	Cardiff LA	Vale LA	Third Sector	Total	Variance
RPB Infrastructure	750,000	767,901	20,000	97,000	5,000	**889,901**	**139,901**
At Home	9,263,732	1,642,319	5,173,782	1,586,004	648,112	**9,050,217**	**(213,515)**
emPower	4,125,354	983,830	2,136,049	672,926	215,100	**4,007,905**	**(117,448)**
Complex Health and Learning Disability	820,328	451,824	174,939	158,310	0	**785,073**	**(35,255)**
Learning Disabilities	1,774,484	236,314	1,022,540	528,708	80,000	**1,867,561**	**93,077**
Unpaid Carers	478,748	41,056	186,174	0	251,782	**479,012**	**264**
ICF Autism	397,728	397,728	0	0	0	**397,728**	**0**
RIF Dementia	1,600,000	1,127,622	238,961	88,000	135,000	**1,589,584**	**(10,416)**
Short breaks	172,237	0	0	0	172,237	**172,237**	**0**
Social Value	45,000	0	0	0	45,000	**45,000**	**0**
Digital	35000	35,000	0	0	0	**35,000**	**0**
Total	**19,462,610**	**5,683,594**	**8,952,445**	**3,130,949**	**1,552,231**	**19,319,218**	**(143,391)**

The forecast end of year position was also reviewed indicating an end of year underspend position of £376k. This is attributable in large part to the lack of clarity on ongoing funding which has led to a number of vacant posts across the programmes.

The Strategic Leadership Group considered and approved a range of proposals for alternative use of the funding by the end of this year, ensuring that priority was given to shared principles and priorities of the partnership. This includes
- £60k for a Market Stability Report to understand the stability and sufficiency of the care market across the region;
- £24k for community-based Dementia Memory Assessment waiting list initiatives;
-£97k to pilot Care Cubed across the region to support enhanced evaluation of proposed care costs.
- £22k to support a service review for Children and Young People at Risk;
- c £230k for a third sector investment fund to support hospital to home initiatives over the coming winter period.
-Various smaller investments of £5k or less to support existing projects.

Progress of each development is being monitored to ensure a balanced end of year position.

Strategic Alignment - 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.**	✓

Impact Assessment:

Risk: Yes

Risk assessments covering data quality, financial activity and actual performance for each priority continue to be reviewed and updated regularly as part of quarterly performance reporting.

Safety: Yes

Safety is a consideration at specific project level where appropriate.

Financial: Yes

The match funding requirement contained within the original RIF guidelines has now been cancelled by the Minister. However, the over-commitment referenced within the main report is a risk which will be closely managed throughout the year to ensure a return within allocation by the end of the year.

We have now received assurance from Welsh Government that RIF funding will be continued into the new financial year. However work is underway to determine the detailed requirements for the future fund and as such all partner organisations are maintaining a holding position until this becomes clear.

Workforce: Yes
The capacity and development of our workforce will be fundamental to ensuring delivery of each project within the RIF. Workforce considerations are included within delivery plans for each project.
Legal: Yes
Any legal implications from delivery of specific commitments will be addressed within the delivery plans for each project area.
Reputational: Yes
The RIF contains a series of challenging commitments for focused work over the next year. It will be important for the UHB to be seen to demonstrate ongoing commitment and support to enabling delivery.
Socio Economic: Yes *The RIF has been developed in direct response to WG guidance which outlines the specific needs of key population groups across our region including those with various socio-economic disadvantages e.g. older people, children, people with learning disabilities, etc. The delivery plans for each project include an overview of engagement intentions and the outcomes to be achieved as a result.*
The Socio-Economic Duty is designed to encourage better decision making, ensuring more equal outcomes. Do the proposals within this report contain strategic decisions, such as setting objectives and the development of services. If so has consideration been given to how the proposals can improve inequality of outcome for people who suffer socio-economic disadvantage? Please include detail. (If this has been addressed in the main body of the report, please confirm)
Equality and Health: Yes
Equality Health Impact Assessments (EHIA) are typically undertaking when developing or reviewing Health Board strategies, policies, plans, procedures or services. Do the proposals contained within the report necessitate the requirement for an EHIA to be undertaken? If so, please include the detail of any EHIA undertaken or the plans are in place to do so. (If this has been addressed in the main body of the report, please confirm) *Given the broad nature of the RIF, Equality Health Impact Assessments (EHIA) will be undertaken for each project where necessary.*
Decarbonisation: No
There are a number of ways by which carbon emissions can be avoided through the operations of CVUHB. *These include:* • *A focus upon preventing ill health in our population* • *Saving energy or increasing throughput.* • *Value based healthcare. Being prudent by not over-treating/intervening. Avoid delivering low-value interventions* • *Patients empowered to manage their conditions, utilising See on Symptoms and Patient Initiated follow ups to reduce unnecessary outpatient appointments.*

- *Service delivery in the most appropriate setting, e.g. in a community setting rather than an acute setting.*
- *Reducing waste – for example use non-sterile gloves only when needed, manage use-by dates to avoid throwing out good products, recycle and reuse.*

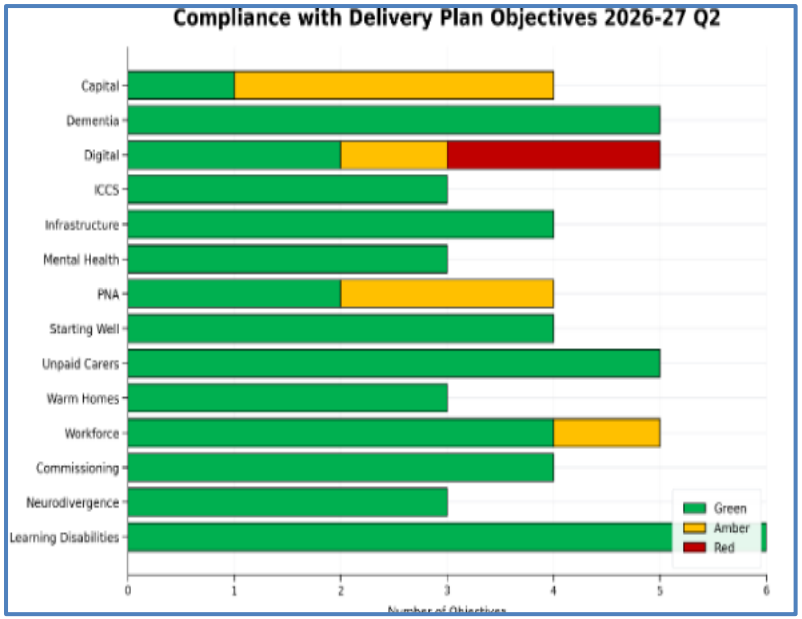
Decarbonisation is a shared commitment for all partners within the RPB and project delivery plans will be required to take this into account where appropriate.

Welsh Language: Yes

Consideration should be given to potential impact on the Welsh language, including the following key aspects:
• More than just words: Does the report align with the More than just words strategy, ensuring Welsh-speaking patients can access services in their preferred language, and supporting active offer and bilingual care?
• Accessibility and compliance: Ensure key information is bilingual and that the report meets the Welsh Language Standards for communication, signage, and patient materials.
• Patient understanding and safety: Could English-only content impact Welsh speakers' comprehension in critical areas like consent and medication instructions, potentially affecting safety?
• Staffing and resources: Does the report address the need for Welsh-speaking staff or bilingual resources to deliver equitable care?
Does the subject matter of your paper risk any of the above not being achieved?

No

Appendix 1: End of Q2 Position 2026-27





Risks and Mitigations

The majority of programmes are progressing well against their stated objectives with a number of highlights:

- Procurement of the next iteration of the Market Stability Report
- Significate progress in the development of our ICCS intentions;
- Development of plans to strengthen our focus on First 1,000 Days.

Several programmes are experiencing delays in key delivery aspects:

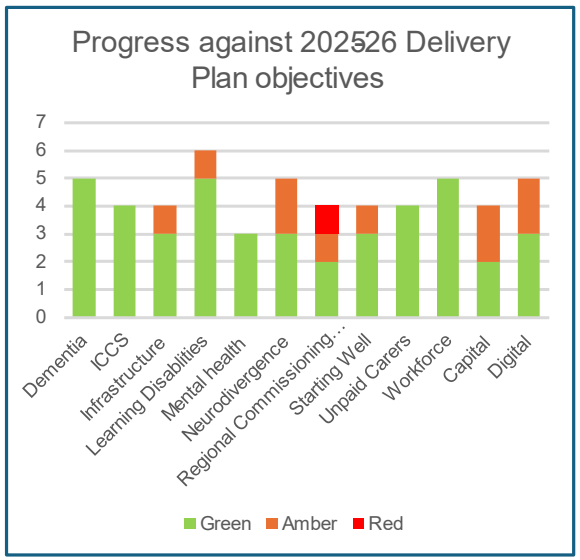
Capital: experiencing delays in the confirmation of start dates and / or new guidance for specific projects. The team continue to expedite progress wherever possible.

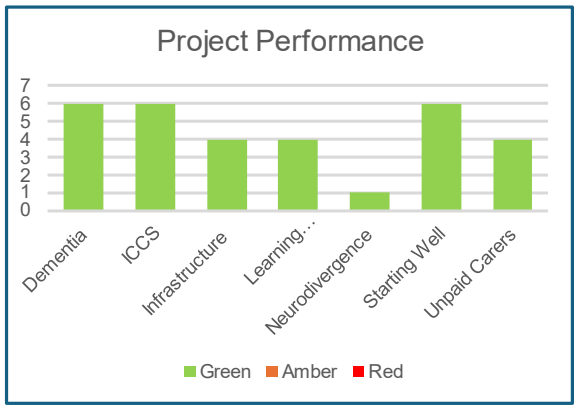
Digital: 2 projects are on hold (Regional Integrated Intelligence and DHCW Connecting Care Integrated Care Record) pending availability of funding. A further project on Future Care Planning is at risk pending decisions on contract renewal. This is being managed through the Digital Care Board.

Population Needs Assessment: delays in initiating proposed chapters for Older People and Neurodivergence due to a backlog in completing work from the previous years. Plans are now being initiated to expedite the development of these chapters.

Workforce: challenges in securing health-related training for local authority staff have been escalated to the health board.

Status





CARDIFF & VALE REGIONAL PARTNERSHIP BOARD

Risks and Mitigation

Infrastructure:

- Amber due to initial delays in Population Needs Assessment work and ongoing development of ministerial engagement outputs, with key activities progressing but not yet fully embedded or delivered.

Learning Disabilities:

- Delays in leadership and governance arrangements (including vacancy of the Head of Partnerships post), alongside ongoing work to address identified inequalities and agree a regional service model, meaning progress is underway but not yet fully secured.

Neurodivergence:

- Need to strengthen consistent representation at board level and further develop structured mechanisms to embed lived experience and avoid duplication across programmes.
- Delays caused by changes to NDIP funding and pending alignment with national guidance, with revised planning now being incorporated into the 2026 –27 delivery plan.

Regional Commissioning Board:

- Ongoing development of regional care definitions and demand analysis, with work still in progress to assess market capacity and align services to meet identified need.
- Significant market pressures and ongoing work to strengthen cost understanding, engagement, and reporting, with key tools such as the dashboard and cost approaches still under development.

Starting Well:

- Shift in scope following partner engagement, with baseline work completed but action planning delayed and now incorporated into the 2026–27 delivery plan to focus on improving value and appropriateness of placements.

Capital:

- Ongoing delivery across multiple schemes, with positive progress on technical scrutiny and funding drawdown but key developments and strategy alignment still in progress.
- Programme no longer progressing as planned within the Capital Team, requiring a review of the approach and delaying further development of cluster -based plans.

Digital:

- Delays in securing final information governance approvals, with technical readiness achieved and pilot deployment pending sign-off before progression to implementation and evaluation stages.
- Progress limited to initial options appraisal and exploratory work, with the decision and implementation phases still pending subject to further development and agreement at regional level.

Progress in line with planned outcomes, Progress falls short of planned outcomes but mitigating action in place. Progress falls short of planned outcomes – unlikely to meet target.