Public Finance and Performance Committee
Wednesday 21st October 2026

10:00	**1. Preliminaries**	Rhian Thomas
1.1	Welcome, Introductions & Apologies	
1.2	Declarations of Interest	
1.3	Minutes from the Finance and Performance Committee meeting – 16.09.2026	
1.4	Actions following the Finance and Performance Committee meeting held on 16.09.2026	
1.5	Chair's Actions since previous meeting	
10:05	**2. Items for Assurance**	
2.1 *20 mins*	Financial Report – Month 6 Position (including Savings Tracker)	Andrew Gough
10:25 2.2 *25 mins*	Operational Performance Update	Paul Bostock
10:50 2.3 *15 mins*	UEC Hospital Flow & Discharge	Mike Bond
11:05 2.4 *15 mins*	Q2 Annual Plan Report	Adam Roberts
11:20	**3. Items for Approval**	
3.1 5 mins	Mental Health and Community Information System	David Thomas
11:25	**4. Items for Noting**	
4.1 *0 mins*	Monthly Monitoring Return – Month 5	Andrew Gough
	5. Private Committee Business	
	I) Commissioning Intentions *II) PwC Update* *III) Forecast Delivery 2026/27* *IV) Haemodialysis*	
11:25	**6. Any Other Business**	
11:25	**7. Close**	
7.1	Items to be deferred to Board / Committee and review of any actions to Future meetings.	Rhian Thomas
7.2	To note the date, time and venue of the next Committee meeting: **Wednesday 18th November 2026 via MS Teams**	

Declaration: 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
16th September 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
Clive Curtis	CC	Independent Member - Community
David Edwards	DE	Independent Member – Digital
Judi Rhys	JR	Independent Member – Third Sector
Rachna Upadhya	RU	Independent Member – General
Susan Lloyd-Selby	SLS	Independent Member – Local Authority
In Attendance:		
Chris Bown	CB	Interim Chief Executive
Adam Roberts	AR	Executive Director of Strategic Planning
Catherine Wood	CW	Deputy 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:		
Obi Hassan	OH	PWC
Iain Alexander	IA	PWC
Apologies:		
Steve Riley	SR	Independent Member – University
Catherine Phillips	CPH	Executive Director of Finance
Paul Bostock	PB	Chief Operating Officer
Ceri Phillips	CP	CAV UHB Vice Chair

Ref:	Agenda Item:	Action
FPC 16.09/1.1	**Welcome, Introductions & Apologies** Rhian Thomas (RT) Committee Chair welcomed everybody to the meeting in English and in Welsh.	
FPC 16.09/1.2	**Declarations of Interest** No declarations of interest were raised.	
FPC 16.09/1.3	**Minutes of the Finance and Performance Meeting held on 22nd July 2026** The minutes of the meeting held on 22nd July 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 17th June 2026 were held as a true and accurate record of the meeting.	

FPC 16.09/1.4	**Actions following the Finance & Performance Meeting on 22nd July 2026** RT introduced the action log review and noted several actions missing from the current papers, including heatwave impact, cancer demand management update, and Welsh Government (WG) funding updates. Catherine Wood (CW) – Deputy Chief Operating Officer updated on the following points: • **June heatwave impact update (action log item)** It was noted system-wide operational impact, workforce effects, and BCI declaration, and outlines debrief learning and recovery lessons • **Cancer demand management position statement (action log item)** It was confirmed the report was circulated to NHS P&I and summarises feedback and intent to include in next committee pack • **Welsh Government development funding update (action log item)** It was noted uncertainty on detail but confirms spend occurred on non-recurrent solutions and cannot yet provide a full breakdown **Action - to provide October committee updates on heatwave impact analysis, cancer demand management statement, and Welsh Government funding/development spend update.** **The Finance and Performance Committee resolved that:** a) The Action Log for the Finance and Performance Committee was noted.	
FPC 16.09/1.5	**Chairs Action since previous meeting** There were no Chair's Actions taken since the last meeting	
FPC 16.09/2.1	**Financial Report – Month 5 Position (including savings tracker)** The DDF highlighted the following points regarding the Financial Report: • A year-to-date deficit of £43.1m compared with a planned deficit of £36.1m, resulting in a £7.1m adverse variance. • The variance was mainly driven by a £9.6m shortfall in planned savings, partially offset by a £2.5m operational surplus. • The main issue is not general overspend but the pace and certainty of savings delivery. • A slight improvement in month 5, with slower deterioration driven by income improvements, some savings delivery, and reduced cost pressures, while cautioning this does not change the overall scale of the challenge. The Interim Chief Executive – Chris Bown (CB) emphasised need for urgent actions to reduce the financial run rate by around £2.5m per month to stay aligned with the control total, acknowledging this may require difficult non-recurrent decisions. The Committee Chair – Rhian Thomas (RT) noted that the committee meets monthly and continues receiving assurances that savings would be de-risked by quarter two, but members are not seeing sufficient change or movement in practice. She asked for CB's observation on whether turnaround meetings and current arrangements have been effective enough to deliver the required improvement and cultural/operational shift. CB stated that the current arrangements were "not sufficient," evidenced by the fact the organisation had not achieved the planned de-risking by quarter two. He confirmed that, with PWC support, a revised and strengthened turnaround governance structure is being implemented to improve cadence, accountability, and control of financial recovery work. He indicated that executive colleagues have agreed to the new structure, which is intended to increase grip, control, and urgency around delivery of savings and recovery actions. The Independent Member for Digital – David Edwards (DE) flagged a discrepancy in the resident doctors' contract figures, noting inconsistency between sections of the report, where	

	one narrative shows a £0.8m pressure and another shows £1.2m. He identified that the £0.8m figure appears in one part of the report (narrative/page reference around page 18 / report page 7), while the £1.2m figure appears in another section (around page 20 / report page 9), raising concerns about alignment across the document. He requested clarification to ensure the financial reporting is consistent and that all figures are clearly understood, noting that even if the difference is not large, consistency is important. AG will correct the report. KW opened by welcoming newly joined observers to the meeting and introduced herself as Chair. She questioned at what point the organisation should formally revise its financial forecast, noting that the ability to deliver the planned deficit was reducing over time. She asked when it would no longer be credible to maintain the current trajectory towards the planned deficit and when a formal change should be made. She asked how the Board would be assured that financial savings could be delivered while still managing associated risks appropriately. She requested clarity on how the Board would be kept informed about risk management approaches and how assurance would be provided that quality and patient safety would not be compromised by cost-saving actions. AG indicated the organisation was not yet at the point of formally changing the financial forecast and remained working against the existing position. He stated there is still optimism that the organisation can achieve the planned deficit, but only if delivery accelerates. He highlighted that achieving the plan depends on improving the speed and certainty of savings delivery through strengthened turnaround actions. He added that the revised turnaround approach and improvements would take a couple of months to properly embed before their full impact and Assurance could be seen. CB highlighted the need to learn from the current year's process and improve planning for future cycles, including 2027–2028. He also referenced that this work is not short-term, but part of a longer-term organisational turnaround over approximately a five-year horizon. He emphasised the need to build ongoing organisational capability for turnaround, not just temporary structures The Director of Corporate Governance – Matt Phillips (MP) explained that QIA work was being led by the Executive Director of Nursing, with planned reporting routes into governance structures to ensure committee assurance. A clear "line of sight" will be created from QIA outputs into the Quality Committee so the board can be assured through that route. The turnaround/QIA interface is being actively discussed to define how it will feed into committee reporting and assurance processes. Work is ongoing to ensure lessons learned from current processes are carried forward, including how the organisation transitions from the external support model while retaining improvements and insights. The Independent Member Local Authority – Susan Lloyd-Selby (SLS) questioned what "pressing clinical boards to accelerate actions" meant in practice and asked for assurance that AMBA schemes would deliver required in-year recurring savings AG confirmed that green and amber schemes (about £24.6m) were currently delivering at full value, but the main risk sits in red pipeline schemes that need conversion or replacement to meet the savings target Obi Hassan (OH) – PWC highlighted the following points: • **Injecting realism into delivery (£102m vs £86.5m target)**: The need to ground expectations was highlighted in the current forecast position and align planning with the reality of the financial gap and delivery challenge. • **Stakeholder journey and honesty in delivery narrative**: Managing stakeholders through the process was critical and that they must be taken through the evolving position rather than maintaining static assumptions. • **Balancing risk, quality, and financial decisions**: The core challenge was balancing clinical quality and financial control, avoiding "slash and burn" approaches, and recognising that risk balancing is central to decision-making.	

- **Programme structure and prioritisation of immediate actions**: There is a need for a staged approach—immediate actions in the short term alongside a broader multi-year transformation programme (around three years).
- **Governance, capability, and risk appetite requirement**: Delivery depends on organisational risk appetite, executive sponsorship, clinical leadership engagement, and clear identification of barriers and capability needs.
- **Urgency and realism of required monthly improvement**: Significant monthly run-rate reductions are required and that expectations must be realistic about the scale and difficulty of change required.
- **Culture and trajectory change as confidence signal**: Demonstrating a shift in organisational culture and financial trajectory would be key to maintaining stakeholder confidence.

DE referenced a previous period where the organisation repeatedly forecasted a relatively stable deficit position, which later increased sharply, resulting in a loss of confidence from Welsh Government in the organisation's forecasts. He linked this experience to current concerns, stressing that without realistic forecasting and stakeholder management, there is a risk of again losing confidence from key stakeholders, including Welsh Government. He highlighted that the organisation is currently on a tight balance between maintaining credibility by sticking to the forecast and the risk of damaging trust if forecasts are not realistic or are poorly communicated.

CB stated that CAVUHB's intention remains to deliver the £86.5m target, but highlighted it is "loaded with risks," including pressures such as winter which could affect delivery. He noted the need to manage expectations with Welsh Government and regulators by making clear that, while the target remains, it carries significant delivery uncertainty. He emphasised that risk appetite is a key factor in decision-making, particularly given constraints around workforce reduction and how savings will realistically be achieved. He also referenced that delivering the required financial position will require balancing ambition with operational constraints and difficult implementation choices.

Iain Alexander (IA) – PWC noted the following:

- **Stakeholder scrutiny & credibility**: Key stakeholders will independently assess the current monthly financial position, and this directly impacts organisational credibility.
- **Need for clear "building blocks" in recovery**: He highlighted the importance of showing a structured progression in savings delivery (moving step-by-step between different scheme levels) to demonstrate how the plan builds credibility over time.
- **Control vs external constraints (WG limits)**: He also stressed that part of stakeholder management is clearly separating what the organisation can control from what it cannot, including areas where Welsh Government policy (e.g., restrictions on redundancy approaches) may limit available options.

KW highlighted that there is a need to examine why CAVUHB continues to struggle with developing effective savings plans, particularly questioning underlying barriers preventing stronger delivery of savings plans. She questioned whether CAVUHB fully understands what has constrained the ability to build more effective savings plans over time, suggesting a need to identify structural or process-related blockers. She raised concern about benchmarking, asking whether the organisation is genuinely benchmarking its savings performance effectively against comparable organisations, given the significant time spent discussing financial shortfalls. She further suggested the organisation may not have been sufficiently ambitious or rigorous in treating savings as part of "business as usual," particularly in the context of a financially challenged system.

AG noted recurrent sustainability depends on aligning service, operational, and workforce planning to the organisation's total resource base of around £2.3bn. The core issue is decision-making trade-offs about how services are delivered within available resources, balancing timing, cost, and model change

	IA noted that NHS England operates under a "totally different funding and financial framework" compared with the current organisation context. He stated that organisations in turnaround situations typically deliver around 4–8% savings, which would equate to roughly £100m for the organisation, highlighting this as a benchmarking reference point. He concluded that the organisation is currently at a very low level of savings compared to what is seen elsewhere in turnaround organisations, reinforcing the gap to typical practice. AG noted the Capital Resource Limit at the start of September was 46.8m, with Welsh Government expected to adjust it (including for known slippage such as Parkview). The Independent Member General – Rachna Upadhya (RU) raised whether the Board has clearly defined its risk appetite across committees (finance, quality, workforce, infrastructure) and whether clear "red lines" exist for decision-making. She questioned if this has been properly quantified and embedded into how trade-offs are made, rather than only discussed at a high level MP stated that risk appetite is formally contained within the Board Assurance Framework and is presented to the Board regularly. He added that work is ongoing to better connect the Board Assurance Framework to planning and decision-making processes, with development underway through executive discussions and planning workstreams RU noted that while risk appetite is discussed across committees, it is not yet clearly translated into defined boundaries that support real decision-making and called for clearer quantification to enable decisions rather than discussion alone. She said that although risk appetite frameworks exist and are referenced (e.g., via the Board Assurance Framework), there is still a gap in how far this translates into actual decisions being taken in practice. She emphasised that more focus is now needed on execution and making difficult trade-off decisions, rather than continued discussion, particularly given the severity of the current situation and need to deliver change in practice **The Finance and Performance Committee noted that:** a) **T**he reported year to date position is an overspend of £43.1m with a planning deficit of £86.5m. b) There is an urgent need to de-risk the £86.5m deficit plan. c) At Month 05 there is an adverse variance against plan of £7.1m, driven by a £9.6m savings deficit, partially offset by an operational surplus against plan of (£2.5m). d) The core savings target of £42.5m is fully covered, although there is an associated material delivery risk linked to the £20.0m 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) That delivery of the deficit plan is contingent on delivery of a full savings programme and confirmation of all expected income streams. f) **T**here are £62.5m of outstanding resource limit allocations and that in due course the UHB expects to seek Finance Committee and Board approval to request £86.5m strategic cash support from Welsh Government to support the planned deficit.	
FPC 16.09/2.2	**Operational Performance Update** The Deputy Chief Operating Officer – Catherine Wood (CW) updated and highlighted the following points on the Operational Performance Update: • **Overview of Performance Report & SPC Charts** • Introduced the performance report and explained use of SPC charts and focus on key variation signals rather than full dataset coverage. • Confirmed the report highlights salient issues from the wider dataset. • **Urgent & Emergency Care (UEC) Performance** • Reported significant operational pressure linked to the heatwave impact and its system-wide effects. • Highlighted ambulance handover performance (W45) stability despite pressure, but rising attendances and longer length of stay in over-75s.	

- Set out “course correction” actions: admissions avoidance, falls pathway improvements, and ward flow transformation (red-to-green, board rounds, discharge planning).
- **Diagnostics & Stroke / Hip Fracture Performance**
- Updated on SNAP tool implementation and data adjustments for stroke/thrombolysis reporting.
- Reported delayed pathways above escalation threshold but with reduced average length of stay and reduced bed days lost.
- **Clinical Coding**
- Reported major improvement in coding timeliness, increasing from 36.2% to 84.5% within 30 days.
- **Cancer Performance**
- Provided updates on single cancer pathway performance (gradual improvement from 60.9% to 64%).
- Explained rising demand and backlog impact on performance metrics.
- Highlighted skin cancer backlog as a key pressure point and outlined corrective actions to reduce waiting times.
- **Planned Care & Diagnostics (104-week waits)**
- Reported funding uncertainty and dependency on Welsh Government allocation for delivery of improvement trajectory.
- Described productivity actions including outpatient overbooking and follow-up conversion programme.
- **Mental Health Performance**
- Reported overall performance on or above trajectory, with significant improvement in out-of-area placements reducing from around 30 to 7 patients.
- **Closing Summary**
- Reinforced overall positive movement in several areas but noted ongoing system pressures and need for continued transformation.

RT highlighted a significant achievement in relation to the significant reduction in out-of-area mental health placements, describing it as a really encouraging update.

CB referred to the reduction in out-of-area mental health placements as a “great result” and questioned whether it would translate into cost savings when he said the reduction was positive but asked if it would actually lead to a measurable reduction in spending on out-of-area placements, specifically whether the financial impact could be tracked through to lower costs.

AG confirmed the ability to track out-of-area placements and stated this tracking was a key driver behind improving the month 5 financial position, linked to reducing the number of patients to around 14 and strengthening both in-month and forecast performance. He also highlighted that the improvement was not just a snapshot effect, but supported increasing confidence in continued reductions going forward, which further supported the improved financial trajectory.

SLS noted positive update that out-of-area mental health placements had reduced through the pilot and asked how the learning is being captured to ensure the improvement is sustained long term. `

CW initially explained that early thinking considered whether the rise in out of area placements reflected a systemic demand and capacity imbalance across the service (i.e., whether the system itself was structurally misaligned). She then clarified her view that it was not primarily a systemic demand/capacity issue, but instead driven more by cultural, behavioural, and process-related factors within the service. She added that sustaining improvement would depend on continuing the work to reset culture, reinforce new behaviours, and embed consistent processes so that the changes become standard practice rather than temporary fixes.

KW Highlighted that outpatient performance had been a longstanding weak area, previously worse than other regions, and noted improvement momentum as positive. Noted progress

	through overbooking initiatives, estimating this could help address a large backlog of missed appointments (around 75,000 additional slots needed to meet targets). She referenced clear Welsh Government expectations for outpatient transformation and sought assurance the organisation would fully implement these requirements. CW confirmed many elements of the WG outpatient expectations were already being implemented, including "see on symptoms," patient-initiated follow-ups, and overbooking clinics with high DNA rates (expected to create ~7,000 additional appointments). She stated there is general movement toward full implementation, but it must be done incrementally due to operational and clinical constraints and concerns raised by clinicians about patient safety and workflow disruption. Indicated that full implementation will require a structured, phased plan and strong clinical engagement, likely over a multi-year horizon, supported by clinical leadership roles and operational planning. KW asked when CAVUHB will receive the outpatient transformation plan and how it will be ensured that it is clinically led, with clinicians fully signed up to delivery and expectations aligned with Welsh Government direction. CW explained that the plan is expected to be developed as a ~2-year programme aligned with WG expectations and broader system timelines. Clinical leadership will be embedded through executive clinical colleagues supporting communication, delivery, and operational design. A planned care clinical lead is being appointed to work alongside operational teams and support clinical engagement and implementation. The approach combines executive clinical leadership and operational clinical leadership to ensure phased implementation and clinician involvement, recognising the scale of change required. SLS highlighted the ENT clinic's approach as a positive example, noting they have already implemented "see on symptoms" type changes and are actively improving outpatient flow by booking additional patients into each clinic session. She referenced clear improvements in waiting times and strong patient communication and acceptance of the changes introduced in ENT services. She concluded that ENT is operating as an exemplar within the organisation and that the learning from this clinic should be shared across other clinical boards to spread best practice. RT highlighted that coding staffing levels have been a longstanding challenge, stating that clinical coding resourcing has been "notoriously challenging over the last few years and beyond" when introducing a question on coding workforce pressures. CW noted that in relation to clinical coding, the performance "speaks for itself", pointing to the significant improvement in coding timeliness and compliance as evidence of progress She explained that the main challenge in this area has been retaining and recruiting specialist coding staff, despite the importance of the function She stated the service has shifted toward "growing our own" workforce model, including creating internal progression routes, rotation opportunities, and developing staff within the service to improve sustainability. CB stated that clinical coding is a widespread issue and highlighted that future improvement should rely on technology rather than traditional manual approaches. He explained that coding processes are well suited to be supported by AI and automation. He noted that the way coding is currently done will change significantly over the coming years, with a shift toward more modern solutions. He emphasised the need to move toward a technological solution rather than outdated approaches. **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 16.09/2.3	**UEC Hospital Flow & Discharge** RT stated that the UEC Hospital Flow and Discharge paper had not been received in time and was therefore removed from the current agenda and deferred to the next meeting.	

	The Director of Operations for Urgent & Emergency Crae – Mike Bond (MB) highlighted the following points: • **Reliable daily routine / ward flow focus** • Described work to standardise ward routines to improve patient flow and reduce delays, including early discharge planning and consistent daily routines across wards. • Highlighted introduction of criteria-led discharges and earlier planning for patient discharge, including structured weekday discharge processes. • **Monday A&E pressure** • Noted Mondays experience 10–15% higher A&E attendances compared with other days, creating system pressure and reinforcing the need for improved flow and weekend discharge patterns. • **Targeted intervention link** • Referenced a targeted intervention aiming for around 33% of discharges before midday, with current performance around 28% in medicine services. • **Pathway delays and partner work** • Described work with partners to address pathway-of-care delays and improve system flow, including reviewing ward-level processes and escalation issues. • **Days lost / performance trajectory** • Stated that despite pressures, days lost were broadly on trajectory and that the system was seeing some stabilisation alongside ongoing improvement work. • **Scaling across wards + system delivery** • Explained the approach is being rolled out across 6 pilot wards initially, with intent to scale across all wards (over 40 in total), supported by structured transformation work. • **Shaping Change support** • Confirmed the Shaping Change team (with Ruth Jordan's team) is supporting implementation and scaling of the flow improvement programme. • **Escalation / SLT reference** • Mike Bond did **not reference SLT** in relation to taking this work forward. • He stated instead that he would be sharing the UEC plan and next steps in **SLP (not SLT)** on Thursday prior to further governance discussions. **Action – MB to bring formal UEC hospital flow & discharge paper to next meeting and scale ward flow model across all wards.** **The Committee resolved that:** a) The UEC Hospital Flow & Discharged would be added to the agenda for October.	
FPC 16.09/2.4	**Diagnostic Deep Dive** CW highlighted the following: a) **Context & challenge framing**: She thanked Sarah Lloyd for compiling the report and noted it reflected a highly detailed view of diagnostics with major concerns around the scale of demand and difficulty in consistently interpreting system movement and variation. b) **Overall demand growth & pressure**: She highlighted significant growth across diagnostic modalities, particularly where demand is increasing faster than capacity. c) **CT demand increase**: Cancer pathway demand increased by ~34.9%, alongside urgent demand growth of ~37%, showing strong pressure across both urgent and cancer pathways. d) **MRI demand increase**: Cancer demand rose by ~34% and urgent demand by ~75%, indicating a marked shift in case mix and urgency profile. e) **System impact of demand shift**: Catherine explained that prioritisation of urgent/cancer cases is impacting lower-acuity pathways, increasing waits for routine diagnostics. f) **Professional alignment**: She noted the demand pattern aligns with Royal College of Radiologists expectations and national trends. g) **Activity increases but insufficient**: Endoscopy activity increased significantly (around 63%), but still not keeping pace with rising demand. h) **Workforce constraints**: She highlighted shortages and pressures in key diagnostic areas including endoscopy, echo, and musculoskeletal ultrasound services.	

i) **Infrastructure failures**: Repeated equipment and infrastructure issues affecting CT, MRI, and endoscopy capacity were identified as a major constraint.
j) **Mitigation approach (short-term)**: Reliance on non-recurrent Welsh Government funding and productivity/efficiency measures was described as currently supporting performance but not sustainable.
k) **Impact of non-recurrent solutions**: Without mitigation, backlog would be significantly higher (~17.5k patients), but current trajectory brings it down to ~3.5k, though still not at desired level.
l) **Next phase of work**: Catherine set out a further deep-dive phase to quantify what would be required to sustainably meet demand, including workforce, infrastructure, and funding implications.
m) **Future decision point**: She confirmed this work will support a strategic board-level decision on whether to fully baseline diagnostic activity or continue mixed non-recurrent approaches.

CB stated that non-recurrent solutions are not a satisfactory long-term approach and highlighted the need to understand the gap between required capacity and current provision to meet demand He emphasised the need for a clearer understanding of the true ongoing cost of meeting demand sustainably, rather than relying on short-term or one-off interventions. He noted that at some stage a decision will be required on making the system sustainable, and that this requires facing up to the financial cost involved. He reinforced that without this understanding, services risk continuing cycles of temporary fixes rather than addressing underlying demand pressures

AR explained that the organisation is on an ongoing improvement journey, with priority given to areas where demand–capacity modelling shows the clearest gaps and risks. He noted that current analysis suggests some services may appear over-resourced, but this is linked to variation in productivity and performance levels rather than a simple staffing excess. He added that improving system-wide performance may require redistributing resources between services, shifting capacity from higher-performing or potentially over-resourced areas to those with greater shortfalls.

CW stated that without mitigating actions and non-recurrent solutions, the system would be facing around 17,500 patients waiting over 8 weeks by year-end, highlighting the scale of avoided backlog due to current interventions.

OH asked whether there is a detailed breakdown of demand drivers and specifically whether analysis exists on screening mechanisms and what is driving the increase in diagnostic demand

CW explained the paper describes significant demand growth and changing demand shape across diagnostics. She noted that while demand patterns align with national expectations, there is uncertainty about the exact level at which this should translate into practice. She would share the paper following the meeting.

RT noted that across services the organisation is managing not only existing demand but also ongoing growth in almost all service areas, and asked what operational work is being done to understand and manage this increasing flow.

CW explained there is currently no single systematic organisation-wide view of demand drivers, but the response is being managed through multiple operational levers including triangulating demand trends, using clinical pathway tools (e.g., health pathways and referral guidance), and reviewing whether all demand is appropriate or could be redirected. She also highlighted actions such as diagnostic stewardship work to better understand test utilisation, and operational productivity measures like overbooking outpatient clinics where DNA rates are high (to increase capacity), alongside wider pathway redesign and prioritisation of urgent and cancer demand, which is reshaping how capacity is allocated across services.

KW raised that primary care (GMS) colleagues may be under significant pressure when managing referrals, particularly where public awareness and expectations influence what

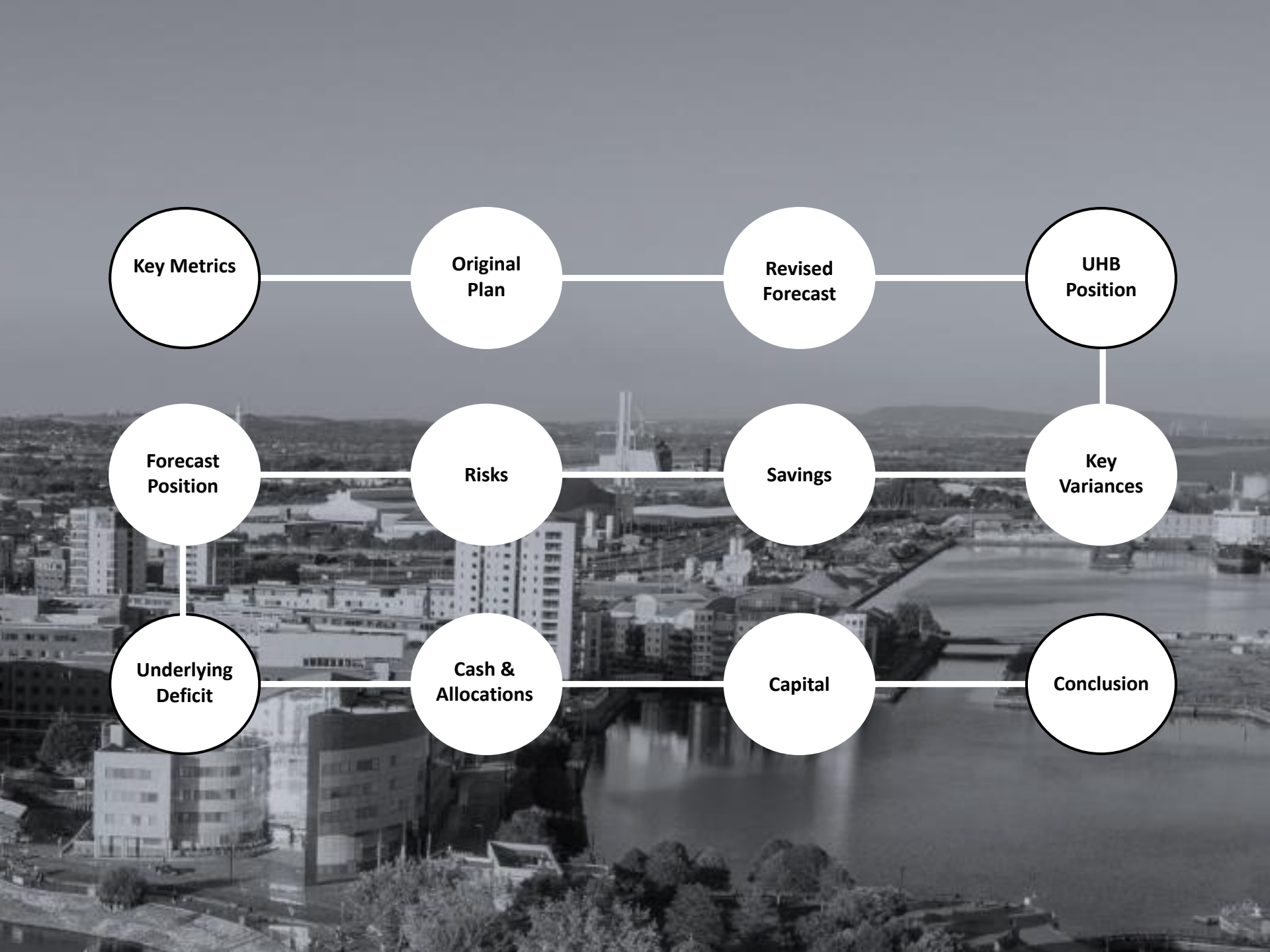
	patients believe should happen in their care. She noted that patients or the public may sometimes expect investigations or referrals that are not clinically appropriate, creating difficult conversations for GPs and placing them in challenging decision-making positions. She sought assurance that the organisation is actively working with primary care colleagues to support them in these decisions and help manage these pressures through appropriate pathways and guidance. CW noted that Cardiff and Vale has the highest adoption and utilisation of healthcare pathways in Wales, describing them as an online library/resource supporting primary care referral decisions. She explained that primary care colleagues use these pathways to seek advice, guidance, and sometimes avoid unnecessary referrals or admissions. referenced a formal primary and secondary care interface group chaired by David Fluck, with LMC involvement, where these issues are discussed and the interface is described as working in both directions. She noted that the group has active/robust discussions on such issues, and highlighted that changes (e.g., skin pathway improvements in secondary care) would have consequential impacts into primary care pathways. **Action – CW to develop phased implementation plan for Welsh Government outpatient reforms with clinical engagement and operational delivery approach.** **Action – CW & AR to develop a fully costed diagnostic demand & capacity plan (including recurrent funding requirements) for return to committee (target end of Q3).** **The Committee noted that:** a) The deterioration in diagnostic waiting-time performance since March 2026. b) The recurrent demand-capacity deficits across Radiology, Endoscopy and Cardiology. c) The Welsh Government diagnostic recovery funding request. d) The integrated diagnostic recovery programme was endorsed. e) The principal risks to delivery. f) Support monthly trajectory, performance and recovery assurance reporting via the Productivity and Efficiency Board.	
FPC 16.09/2.5	**Grip & Control** AG highlighted the following points on Grip & Control: • **Overall assessment of controls** Confirmed the organisation has a substantial underlying financial control framework already in place, including core financial, procurement, workforce and reporting controls, but these are not applied consistently across all areas. • **Core issue identified** Emphasised the key gap is not the absence of policies, but the difference between having controls in place and ensuring they are effective and consistently used in practice. • **Nature of the weakness** Highlighted that the main problem is inconsistent application, weak escalation of exceptions, and lack of assurance that corrective action reliably changes outcomes. • **Root cause framing** Described the issue as an operational discipline and follow-through problem rather than a structural or policy deficit. • **Integration into turnaround approach** Stated that grip and control actions will be embedded into the wider integrated improvement plan rather than managed as a standalone finance action list, ensuring organisational ownership beyond finance. • **Ownership and accountability** Confirmed responsibility for delivery will sit with relevant executive directors and operational leadership, with finance providing challenge, support and assurance. • **Success criteria / expectations** Set expectation that success will be measured by whether actions are delivered, exceptions trigger intervention, and interventions lead to measurable behavioural and performance change.	

	• **Future assurance approach** Noted that progress will be revisited through reassessment cycles over the coming months to confirm whether improvements are embedded and effective. SLS raised that issues reported through People & Culture include some unexpected gap. She highlighted that there is no single organisation-wide policy covering the use of temporary staffing. She requested clarity on how issues identified in P&C are properly escalated and "read across" to other relevant committees AG Confirmed that actions linked to the grip and control plan will have designated executive/operational owners. These owners are expected to ensure reporting and escalation into the appropriate committees as part of delivery MP noted that governance and performance management structures should ensure issues are routed to the right committees, including P&C, through integrated reporting. AR added that revised senior leadership forums will improve awareness of key performance and control issues, supporting better cross-organisational visibility. **Action – AG to confirm delivery timescales and provide completion evidence for all grip & control actions.** **Action – AR to embed grip & control actions within the integrated improvement plan and ensure committee read-across (take this off-line).** **The Committee noted that:** a) The final Grip and Control self-assessment and the areas of relative strength and weakness identified; b) The actions already underway and the further improvements required; c) Delivery will be led by the relevant Executive Directors, supported by their deputies and nominated operational leads; d) Executive Directors and deputies were required to confirm delivery timescales and completion evidence for each action; e) The development of a consolidated Grip and Control Improvement Plan was to be endorsed and: f) Progress was required, overdue actions and material exceptions to be reported through the Finance and Performance Committee and relevant executive governance arrangements.	
	Monthly Monitoring Return	
FPC 16.09/5.0	**Any Other Business** No further business was raised.	
FPC 16.09/6.0	**Review & Close** To note the date, time and venue of the next Committee meeting: **Wednesday 21st October 2026 via MS Teams**	

MEETING	Title	Minute Reference	Agreed Action	Executive Lead	Action Lead	Date Assigned	Date for Review	Action Status	Action Update
FINANCE & PERFORMANCE	Operational Performance Update	2026/07/201	To provide a detailed analysis of the June heatwave impact on operations and diagnostics at the next meeting.	Paul Bostock	Paul Bostock	22/07/2026	21/10/2026	ON FORWARD PLAN	This has been added to the forward plan for 21.10.2026.
FINANCE & PERFORMANCE	Operational Performance Update	2026/07/2.2	to submit a position statement on cancer demand management to NHS P&I and include it in the next committee report.	Paul Bostock	Paul Bostock	22/07/2026	21/10/2026	ON FORWARD PLAN	This has been added to the forward plan for 21.10.2026.
FINANCE & PERFORMANCE	Operational Performance Update	2026/07/2.2	To bring an update on neurodevelopment plans and spending of allocated Welsh Government funds to the next F&P meeting.	Paul Bostock	Paul Bostock	22/07/2026	21/10/2026	ON FORWARD PLAN	This has been added to the forward plan for 21.10.2026.
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	16/09/2026	20/01/2027	ON FORWARD PLAN	This has been added to the forward plan 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	16/09/2026	20/01/2027	ON FORWARD PLAN	This has been added to the forward plan for 20.01.2027.
FINANCE & PERFORMANCE	UEC Hospital Flow & Discharge	FPC 16.09/2.3	To bring formal UEC hospital flow & discharge paper to next meeting and scale ward flow model across all wards.	Paul Bostock	Mike Bond	16/09/2026	21/10/2026	ON FORWARD PLAN	This has been added to the forward plan for 21.10.2026.
FINANCE & PERFORMANCE	Grip & Control	FPC 16.09/2.5	To confirm delivery timescales and provide completion evidence for all grip & control actions.	Catherine Phillips	Andrew Gough	16/09/2026	18/11/2026	ON FORWARD PLAN	This has been added to the forward plan for 18.11.2026.
FINANCE & PERFORMANCE	Grip & Control	FPC 16.09/2.5	to embed grip & control actions within the integrated improvement plan and ensure committee read-across (take this off-line).	Adam Roberts	Adam Roberts	16/09/2026	21/10/2026	COMPLETE	This is action is to be completed off line / outside of the meeting.

CARDIFF & VALE UHB
FINANCE REPORT – MONTH 06




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	M06 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 £26.9m after Month 06.	R	↓	£77.4m	M06 2026/7
Management of operational budget pressures	Failure to adequately manage budget pressures. This is the responsibility of the primary budget holders. £2.6m operational surplus reported at Month 06.	A	→	Operational Spend to be maintained within Budgets	M06 2026/7
Delivery of the **recurrent** £42.5m core & £5.1m JCC savings target	£27m of Green and Amber-rated schemes had been identified by Month 6, of which £20.7m were classified as recurrent.	R	↑	£42.5m plus £5.1m (47.6m in total)	M06 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	M06 2026/7



Following confirmation at Month 6 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	(9.2)
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:

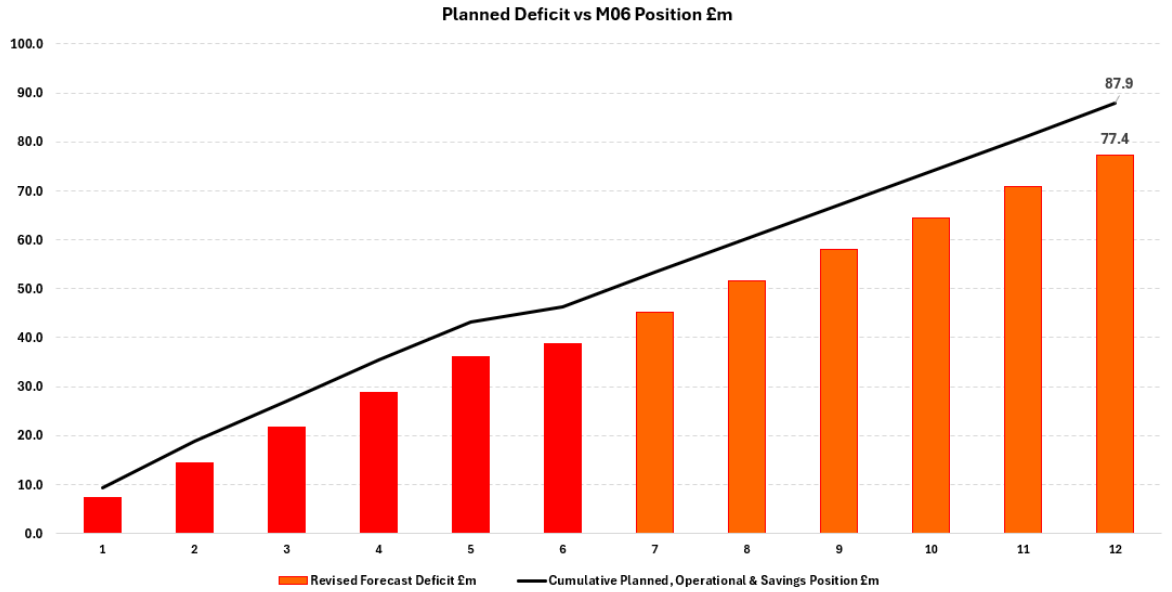
- £2.3m – Band 2-3 HCSW Implementation
- £2.1m – Increase in Employers National Insurance
- £0.9m – Mental Health Out of Area patients
- £0.8m – GP OOHs Contract
- £0.7m – Common Ailment Scheme
- £0.6m – Midwifery Streamliners

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 06 position against the UHB's revised forecast deficit of £77.4m



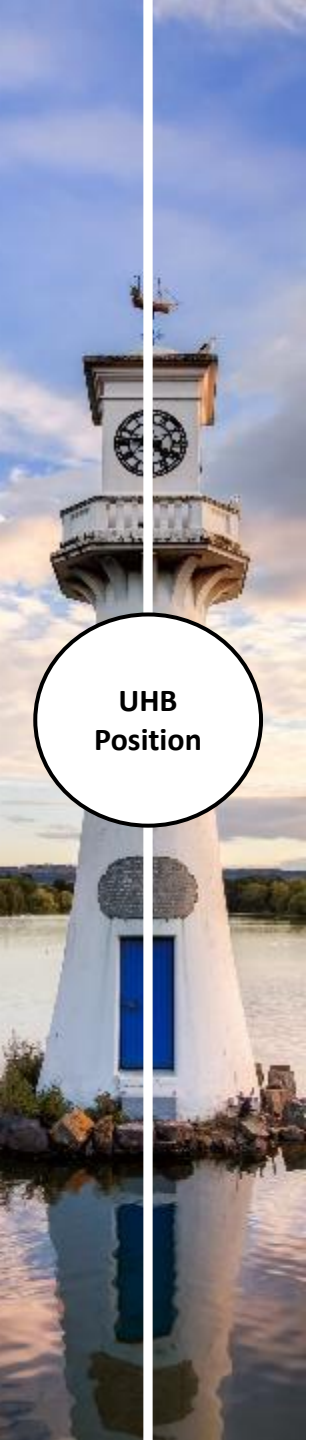
	1	2	3	4	5	6	7	8	9	10	11	12
Revised Forecast Deficit £m	7.2	14.4	21.6	28.8	36.1	38.7	45.1	51.6	58.0	64.5	70.9	77.4
Cumulative Planned, Operational & Savings Position £m	9.4	18.8	27.1	35.5	43.1	46.4	53.3	60.2	67.1	74.0	80.9	87.9
Actual/ Forecast Deficit above Plan £m	2.2	4.4	5.4	6.7	7.1	7.7	8.1	8.6	9.1	9.5	10.0	10.5
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 proportion to the revised forecast deficit, consistent with Welsh Government Monthly Monitoring Return guidance. The change in trajectory at Month 6 reflects the revision to the forecast planning deficit following confirmation of the reduced contribution to the Welsh Risk Pool.

The current forecast outturn is a deficit of £87.9m 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 £46.4m at month 06, which includes the forecast planning deficit £38.7m, a Savings Programme shortfall of £10.3m and an Operational Position surplus (£2.6m)

	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	5.8	5.8	0.0	59.6	59.6	0.0	125.0	125.0	0.0
Quality Efficiency Improvement Plans - Savings	3.2	2.2	1.0	20.9	10.6	10.3	47.6	27.0	20.6
Operational Variance	0.0	0.4	0.4	0.0	2.6	2.6	0.0	10.1	10.1
Clinical / Service Board Variance	**2.6**	**3.2**	**0.6**	**38.7**	**46.4**	**7.7**	**77.4**	**87.9**	**10.5**

The rate of overspend slowed again during the month, reflecting an improvement in savings delivery.

The revised forecast deficit of £77.4 million requires urgent mitigation if it is to be achieved. Key risks to delivery currently include:

1. **Savings Delivery**
   - An in-year shortfall of £15.5 million against the core £42.5 million savings target and with an additional £5.1 million shortfall against the JCC savings target.
   - The current red-rated savings pipeline totals £20.4 million. While full delivery would achieve the core savings target, there is a significant risk that not all schemes will be realised, requiring further opportunities to be identified
   - Schemes to deliver the JCC £5.1 million (2%) efficiency target have yet to be identified, with work ongoing with JCC to develop and implement suitable savings schemes

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

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



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	57.7	89.7	99.0	**131.0**
(Income)/Expenditure	57.5	90.2	101.5	**134.2**
Variance	**0.2**	**0.5**	**2.5**	**3.2**
Cumulative	**£'m**	**£'m**	**£'m**	**£'m**
Budget	339.6	541.7	556.6	**758.6**
(Income)/Expenditure	339.6	540.8	603.7	**805.0**
Variance	**0.1**	**0.9**	**47.1**	**46.4**

A number of operational pressures continued into month 06 which in turn have been offset by pay vacancies.

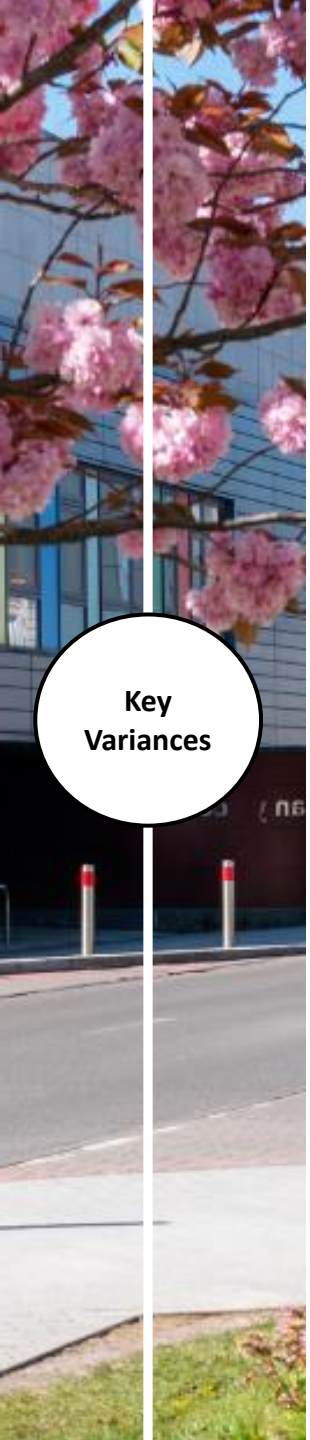
The following operational issues were reported at month 06 in 2026/27:

The analysis above indicates a year-to-date overspend of £46.4 million, which is £7.7 million adverse to the forecast year-to-date deficit of £38.7 million

- Income – A Year to date 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 a pay underspend, partially offset by pressures associated with specialist medical locum expenditure. Phase 1 of the new Resident Doctors' Contract was implemented in August. Based on the information currently available, the estimated additional cost pressure above plan in 2026/27 is £1.2m. This estimate will be kept under review as further payroll data 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:

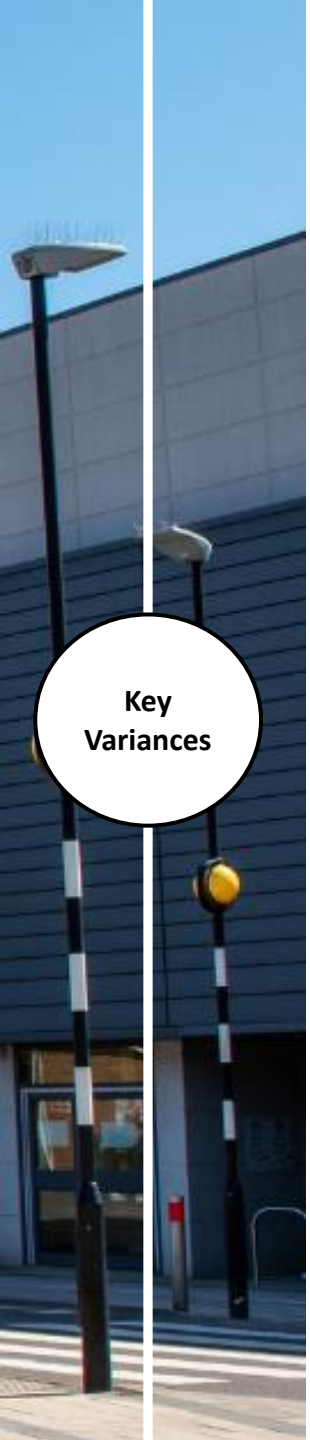
Business Unit	Forecast Deficit (£m)	Savings (£m)	Operational (£m)	Total (£m)	Variance to Forecast Deficit (£m)
Clinical Diagnostics & Therapeutics	0.8	1.2	0.4	**1.6**	0.8
Children & Women	3.3	3.0	0.2	**6.1**	2.8
Capital, Estates & Facilities	1.0	1.0	0.9	**0.9**	0.1
Executives	0.6	0.7	0.6	**0.5**	0.1
Genomics	0.2	0.0	0.0	**0.2**	0.0
Medicine	7.1	0.4	0.3	**7.0**	0.0
Mental Health	5.3	0.9	2.3	**8.5**	3.1
Primary, Community & Intermediate Care	4.3	0.1	3.4	**0.8**	3.5
Specialist	2.7	3.9	1.5	**8.2**	5.4
Surgery	1.0	1.1	0.4	**1.7**	0.7
Sub-Total (Delegated Position)	**23.1**	**11.3**	**1.8**	**32.7**	**9.5**
Central Budgets	2.7	0.0	0.3	**3.0**	0.3
Commissioning	12.8	1.0	1.1	**10.7**	2.1
Sub Total (Non-Delegated Position)	**15.5**	**1.0**	**0.9**	**13.7**	**1.9**
Sub-Total Surplus/ Deficit	**38.7**	**10.3**	**2.6**	**46.4**	**7.7**



The table/chart below summarises the key 2026/27 Operational pressures as at month 06:

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**

- The forecast endoscopy pressure is being offset by scheme slippage and pay vacancies.
- Mental Health out of area patients (average of 21 patients)
- Specialist Medical Locum use is primarily driven by cardiology
- 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.



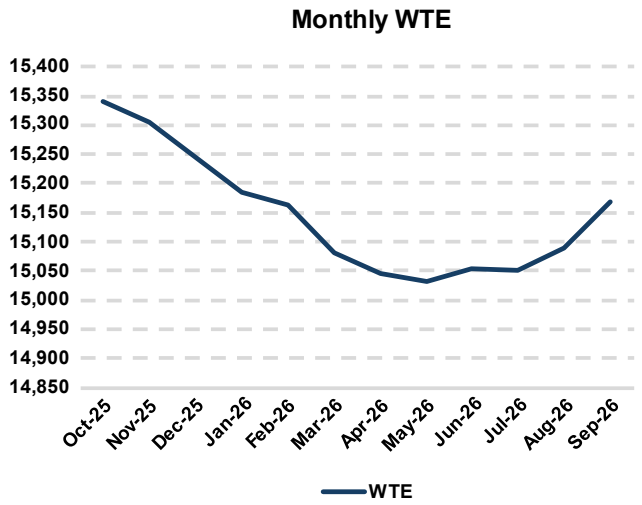
Key Variances

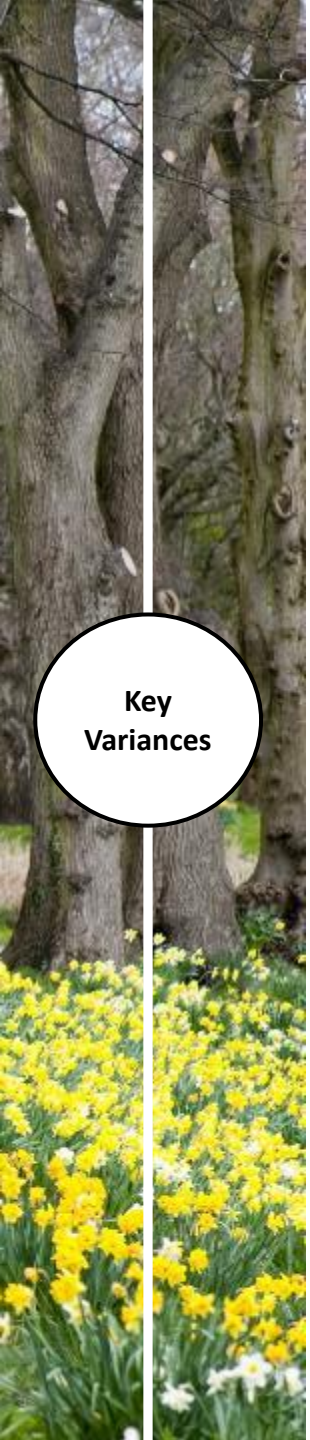
The table/chart below summarise the 2025/26 & 2026/27 Pay expenditure run rates at month 06 for all staffing groups :

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	19.4	19.3	(0.1)	-0.4%
Management, Admin & Clerical	64.2	65.9	1.7	2.6%
Medical and Dental	145.4	150.9	5.5	3.8%
Nursing (Registered)	148.3	154.1	5.8	3.9%
Nursing (Unregistered)	43.9	45.0	1.1	2.4%
Other Staff Groups	77.5	80.5	2.9	3.7%
Scientific, Prof & Technical	24.2	25.2	1.0	4.2%
Total	**522.9**	**540.8**	**17.9**	**3.4%**

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 174 WTE reduction across the UHB over the last 12 months. The increase in staff WTEs during September and October 2025 relates to the onboarding of registered nurses from the nurse student streamliner programme. From November through to September, WTEs in post have declined overall. WTEs increased in September due primarily student streamliners in Allied Health Professionals and Nursing, with the growth expected to continue 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	65.6	68.0	**2.4**	**3.7%**
Continuing Healthcare	58.6	65.3	**6.7**	**11.5%**
Drugs / Prescribing	134.9	141.0	**6.2**	**4.6%**
Healthcare Provided Services	146.5	154.5	**8.0**	**5.5%**
Other Non Pay & General Supplies and Establishment Expenses	52.2	56.8	**4.6**	**8.9%**
Premises & Fixed Plant	26.4	27.9	**1.5**	**5.6%**
Primary Care Contractors	82.5	90.2	**7.6**	**9.2%**
Total	**566.6**	**603.7**	**37.1**	**6.5%**

The UHB reported **£603.7m** of Non Pay expenditure for the Year to Date to September 2026 which is an increase of 6.5% 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)
- Healthcare Provided Services. Additional Commissioning costs including Mental Health Out of area Placements, Velindre NHST and JCC under Healthcare Provided Services. (£3.4m 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 06, the UHB has identified £27.0m of green and amber savings towards the core £42.5m savings requirement. In addition, £20.4m of red-rated schemes have been identified, meaning that the core savings target is currently more than covered if all red schemes are delivered. However, reliance on these red-rated schemes increases the level of delivery risk associated with achieving the target.

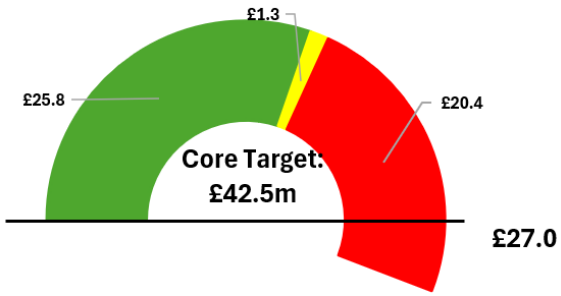
There are not yet schemes in place to deliver the JCC £5.1m 2% efficiency target.

Further action is required to meet the recurrent targets and the UHB will continue to press all parts of the organisation to agree urgent actions that will accelerate savings to mitigate the ongoing risk. £20.7m of recurrent savings were identified at month 06 leaving a gap of £21.8m against the £42.5m core recurrent target.

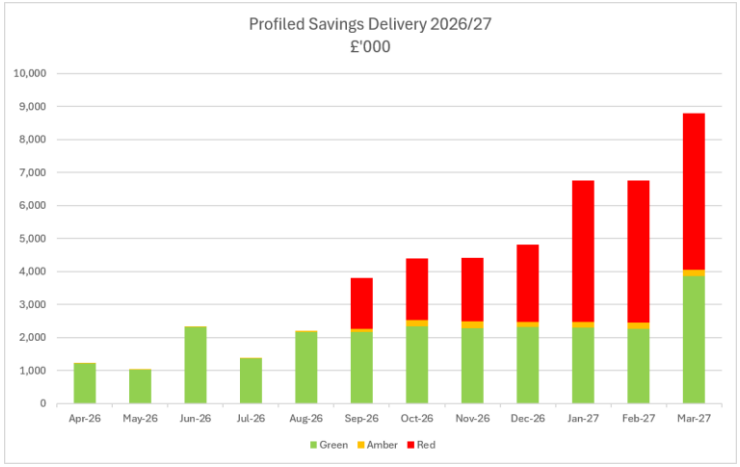
If the recurring savings shortfall is not addressed, the underlying deficit will increase by £21.8 million relating to the core savings target shortfall, together with a further £5.1 million associated with the JCC efficiency target.

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

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



Area of Cost Improvement	Total Savings & Opportunity £m	2026/27 Ambition £m	Green £m	Amber £m	Red £m	Scheme development & progress required £m
Workforce/Productivity Deployment	11.7	10.3	3.9	0.8	10.2	(4.6)
CHC	7.8	7.8	2.7	0.1	0.6	4.4
Length of Stay - Non Elective	39.6	1.6	0.0	0.0	3.9	(2.3)
Grip & Control	8.0	8.9	5.1	0.1	2.8	1.0
Medicines Management	8.7	5.8	7.3	0.0	0.1	(1.6)
Planned Care Productivity	7.0	0.0	0.1	0.0	0.0	(0.1)
Procurement	4.0	4.0	2.6	0.2	1.2	(0.0)
Other	9.4	4.1	4.1	0.1	1.7	(1.8)
Total	**96.2**	**42.5**	**25.8**	**1.3**	**20.4**	**(5.0)**





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)
CD&T	4.9	2.8	0.0	**2.8**
Children & Women	7.4	2.7	0.2	**2.9**
Capital, Estates & Facilities	2.9	0.8	0.0	**0.8**
Executives	1.8	0.4	0.0	**0.4**
Genomics	0.0	0.6	0.0	**0.6**
Medicine	3.2	3.7	0.6	**4.3**
Mental Health	4.0	2.2	0.1	**2.3**
PCIC	3.0	3.2	0.0	**3.2**
Specialist	8.0	4.2	0.1	**4.4**
Surgery	6.1	3.9	0.2	**4.1**
Corporate	1.2	1.2	0.0	**1.2**
Total Surplus/Deficit	**42.5**	**25.8**	**1.3**	**27.0**

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 (£20.4m) 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 £20.4m red pipeline includes the additional measures agreed by the Executive Team, principally:

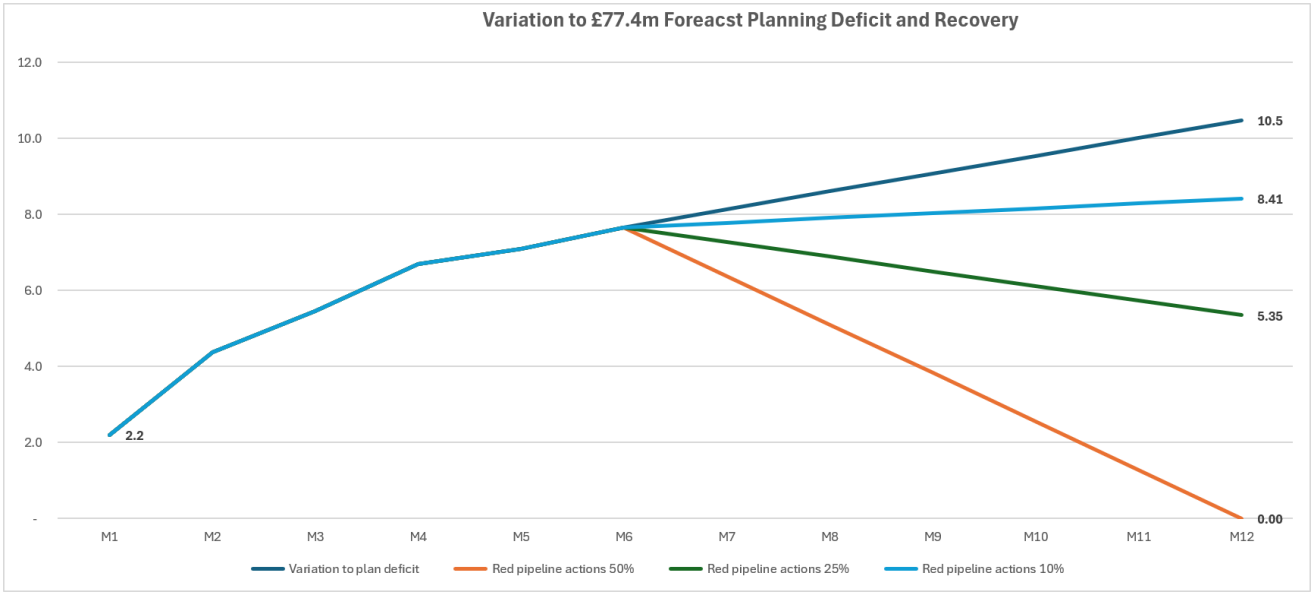
- a 380 WTE vacancy hold, based on retaining 50% of turnover arising between 1 August 2026 and 31 March 2027; and
- a 10% reduction in bank expenditure.
- a 30% agency reduction in line with the national target
- acute bed capacity reduction and remodelling



Financial Recovery

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

At month 6 the Health Board's gross forecast before recovery actions is £87.9m. This is £10.5m over and above Welsh Governments expected forecast deficit of £77.4m. **The forecast scenarios include delivery of red pipeline schemes. c50% 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 September 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.	20
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.

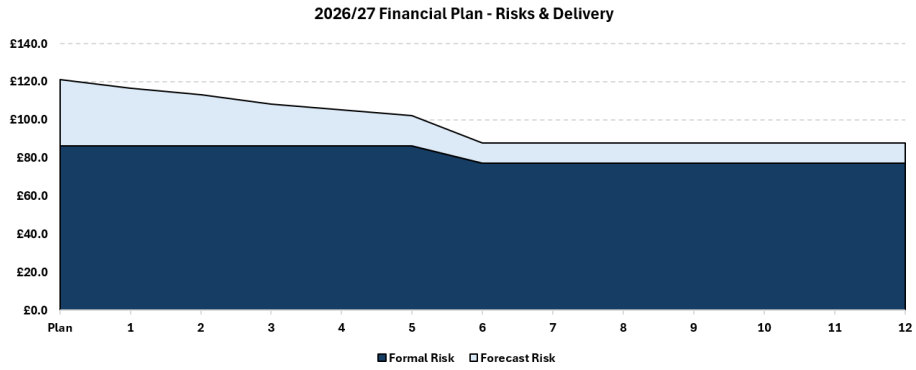
The planned deficit has been reduced from £86.5 million to a forecast deficit of £77.4 million in month, reflecting a £9.1 million reduction in the UHB's expected contribution to the Welsh Risk Pool for 2026/27 confirmed in month 6

At Month 06, the UHB's savings tracker reported a £20.6m 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 £10.1m is forecast.

The resulting £10.5m 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**	**20.6**	**20.6**	**20.6**	**20.6**	**20.6**	**20.6**
Cumulative Savings Shortfall/ (Surplus)	0.0	29.2	28.2	27.7	24.2	23.0	20.6	20.6	20.6	20.6	20.6	20.6	20.6
Forecast Cumulative Operational Pressures	0.0	0.9	(1.5)	(6.1)	(5.4)	(7.2)	(10.1)	(10.1)	(10.1)	(10.1)	(10.1)	(10.1)	(10.1)
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**	**10.5**	**10.5**	**10.5**	**10.5**	**10.5**	**10.5**

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 £104.3m 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 06	26.9
Forecast Underlying Deficit (ULD) at end of 2026/27 without further identification of Savings & Actions	104.3

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 September was £3.286m.

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:

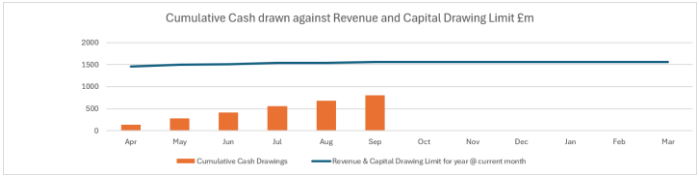
- Capital: £12.000m to support 2025/26 year-end capital creditors.
- Revenue: £6.498m to support 2025/26 Revenue Resource Limit adjustments that are not backed by cash, principally relating to Health and Social Care Worker recognition payments

The additional cash support required will continue to be reviewed as the year progresses.

The value of unconfirmed drawing and resource limit allocations at month 06 was £51.0m & £87.8m respectively as outlined opposite.

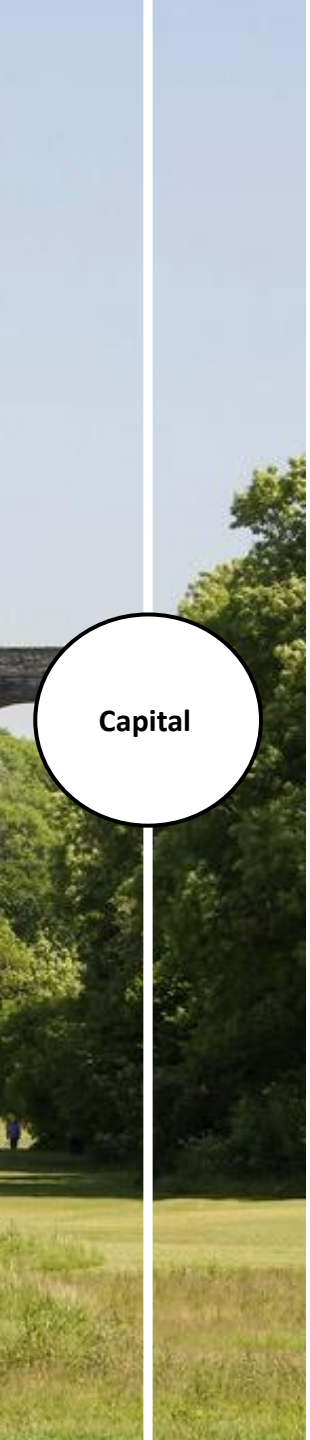
The cumulative cash drawn at the month end against the UHBs cumulative annual cash drawing limit is illustrated by the graph to the right.

Unconfirmed Drawing and Resource Limit Allocations as of 30th September 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		36.8
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	0.3	0.3
Integration And Rebalancing Capital Fund (IRCF)	0.5	0.5
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)
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	**51.0**	**87.8**



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 September was 96.5% for the year to date.



Capital

The UHBs approved Capital Resource Limit issued by Welsh Government as at the 6th October was £47.238m.

This included

- **£16.842m** discretionary funding
- **£30.258m** 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)	M6 Ytd			Annual	CRL	Orders	Orders
	Actual	Plan	Variance	Plan	06 Oct 26	Raised	Receipted
All Wales Schemes							
Lift Refurbishment and Upgrade, UHW	0.023	1.100	(1.077)	2.854	2.854	2.383	0.023
Pentyrch Branch Surgery Development 2024-26	0.395	0.762	(0.367)	0.762	0.762	0.763	0.395
Haematology Day Centre Extension, University Hospital of Wales	0.079	0.454	(0.374)	1.089	1.089	1.109	0.079
TEF - Fire	0.122	0.207	(0.085)	0.362	0.362	0.225	0.122
TEF - Infrastructure	0.004	0.477	(0.473)	2.552	2.552	2.285	0.004
TEF - Decarbonisation	(0.000)	0.067	(0.067)	0.329	0.329	0.000	0.000
TEF - Mental Health	0.107	0.171	(0.065)	0.261	0.261	0.107	0.107
TEF - Infection Prevention Control	0.026	0.124	(0.098)	0.448	0.448	0.026	0.026
TEF - Decontamination	0.008	0.043	(0.034)	0.603	0.603	0.316	0.000
Transport Hub and Car Park at University Hospital of Wales	0.045	0.386	(0.341)	0.386	0.386	0.436	0.045
Diagnostic Investments 2026-27	0.000	0.746	(0.746)	3.731	3.731	0.000	0.000
Electrical Infrastructure, Tertiary Tower Block at UHW	0.371	0.696	(0.325)	0.310	0.310	0.310	0.422
Estates & Equipment End of Year Funding 2025-26	0.304	0.813	(0.509)	0.813	0.813	0.429	0.304
Mental Health Quality and Safety Schemes	0.164	0.388	(0.224)	0.388	0.388	0.537	0.164
Hospital Helicopter Landing Site Schemes 2025-26	0.093	0.111	(0.018)	0.111	0.111	0.153	0.093
End of Year Funding - January 2026	0.453	0.323	0.130	0.649	0.649	0.389	0.382
UHW Ward Block Roof Replacement	0.007	0.773	(0.766)	2.258	2.258	1.756	0.007
Mental Health Quality and Safety Schemes 2026-27	0.000	0.114	(0.114)	0.456	0.456	0.000	0.000
Park View Health and Wellbeing Hub	0.007	0.002	0.005	5.691	7.636	0.007	0.007
DPIF - Digital Maternity	0.000	0.000	0.000	0.050	0.050	0.000	0.000
Estates Backlog Funding	0.000	0.000	0.000	1.550	1.550	0.000	0.000
Digital Backlog Funding	0.000	0.000	0.000	2.320	2.320	0.000	0.000
DPIF - Electronic Prescribing and Medicines Administration (ePMA)	0.000	0.000	0.000	0.340	0.340	0.000	0.000
IFRS16	0.000	0.000	0.000	0.138	0.138	0.000	0.000
IM&T:	0.380	0.900	(0.520)	3.016	1.000	0.386	0.323
Equip	0.246	0.500	(0.254)	1.000	1.000	0.370	0.251
Stat comp	1.063	0.880	0.183	2.600	2.800	2.243	1.013
Other	1.128	2.498	(1.370)	10.226	12.042	3.054	0.767
Total	**5.024**	**12.533**	**(7.509)**	**45.293**	**47.238**	**17.283**	**4.533**

A review of capital scheme slippage is underway in line with Welsh Government reporting requirements, for submission on 16 October. The review and subsequent discussions with Welsh Government will determine revisions to the 2026/27 Capital Resource Limit (CRL).

Park View forecasts slippage of £1.945m. As part of this review, Welsh Government will issue a revised CRL to reflect the scheme's reduced funding requirement.



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.

At Month 06 the Committee is requested to:

- **NOTE** the reported year to date position is an overspend of £46.4m 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 £10.5m gap to delivery.
- **NOTE** 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).
- **NOTE** 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
- **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 £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 Welsh Government to support the forecast deficit.

Report Title: *(needs to match agenda)*	Operational Performance Update		Agenda Item No:		2.2
Meeting:	Finance and Performance Committee	Public	x	Meeting Date:	21.10.2026
		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:*	
***When** it went:*	
***What** decision was made:*	*e.g. Recommended to Board for approval*

Main Report

Background & Current Situation

Urgent and Emergency Care

August and September have seen periods of operational pressure, with attendances increasing in September 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 9.5% in August to 8.9% in September but remains above our de-escalation standard of 7%.

Stroke and Hip Fractures

We are working with NHS P&I to ensure that all regional and OOH stroke activity is attributed accurately and in a timely manner. Door to ward compliance for the Stroke unit was challenged through June and July but improved in August. September data can be updated verbally at committee. The most recent Stroke stocktake took place in October, bringing together clinicians and senior leaders with particular focus on the EU pathway for self-presenting patients. In August 22.7% of hip fracture patients were admitted within 4 hours, remaining above the UK average of 9.9%

Delayed Pathways of Care

September saw an expected fall in DOPC to 162, in line with previous years. This remains above our de-escalation criteria of 128. The average days delayed increased from 42 in August, to 50 in September but the total bed days lost was reduced by c1500 from September '25. Assessment issues and Care Home placement arrangements 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 87.1% compliance in June, improved from April and May, and significantly improved from the 53.3% reported in June'25.

Cancer

Compliance with the SCP remains above our de-escalation requirement in Q2; 64.4% of patients received their treatment within 62d in July, falling to 60.4% in August. The total waiting list remained increased from last year. This trend has seen the SCP waiting list grow by c33% since 2024. Increased demand has been a key driver of this, with the volume of patients accepted onto the SCP increasing by c70% over the past 5y. We are taking actions in key tumour sites, including additional Consultants in UGI and Urology, and specialty doctor/fellow recruitment in Skin. In August, 5 tumour sites met the SCP standard of 75%, including UGI and skin. In the short term we continue to see high volumes on patients on the waiting list and patients waiting >62d and expect performance to drop in September.

Planned Care and Diagnostics

Waits for NOP remains reduced. Our focus this year remains on productivity, including increased use of SOS/PIFU, review of clinics with high DNAs, validation of uncashed clinics and focus on activity. Our first Productivity and Efficiency Board meetings have taken place in Q2 for Executive oversight, supported by a new PowerBI resource, these continue monthly. We have seen increases in 2y waits, in-line with our forecast; driven by Dermatology, General Surgery and Orthopaedics. In September we reported 1245 patients waiting 104 weeks or more. We have developed plans, internally and with regional partners to eliminate 2y waits regionally in as many specialties as possible. Funding allocations have been confirmed and we are mobilising our plans across the key specialties. The number of 3y waits remains zero. Diagnostic 8w waits reduced in August. Driven by a reduction on waits for NOUS. This represents 49% of patients waiting less than 8w, below our de-escalation standard of 80%. A separate paper on diagnostic plans was presented last month. September'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, but performance plateaued at c70% in Q1.

Work is ongoing to redistribute the CTPs within teams to boost compliance, with increases noted in June, July and August.

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

IPR Performance metrics

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

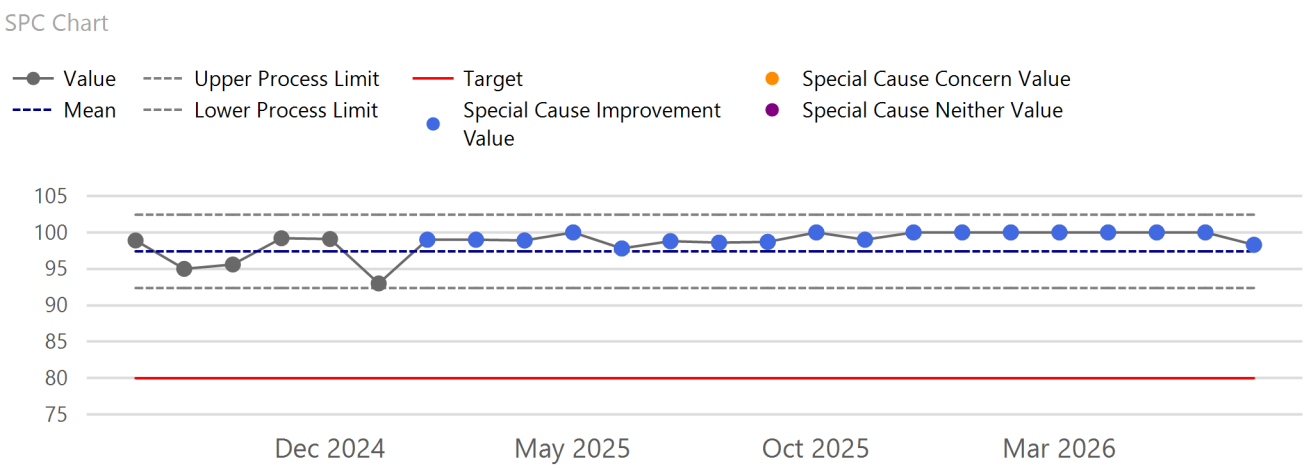
- *Does the report align with the More than just words strategy, ensuring Welsh-speaking patients can access services in their preferred language?*
- *Ensure key information is bilingual and that the report meets the Welsh Language Standards for communication, signage, and patient materials.*
- *Does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

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
July 2026	98.3	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

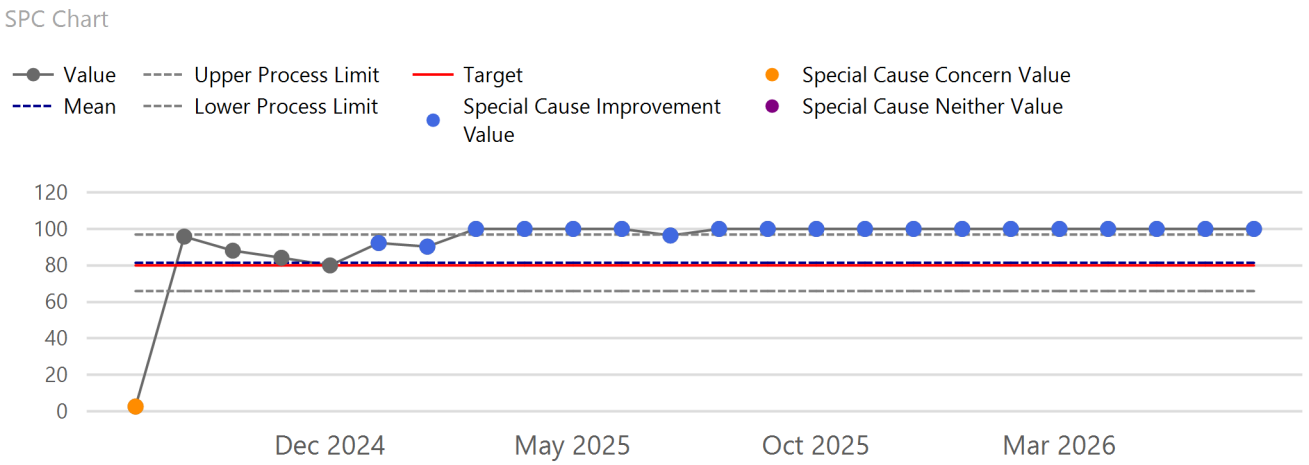
Concerns

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
July 2026	100	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

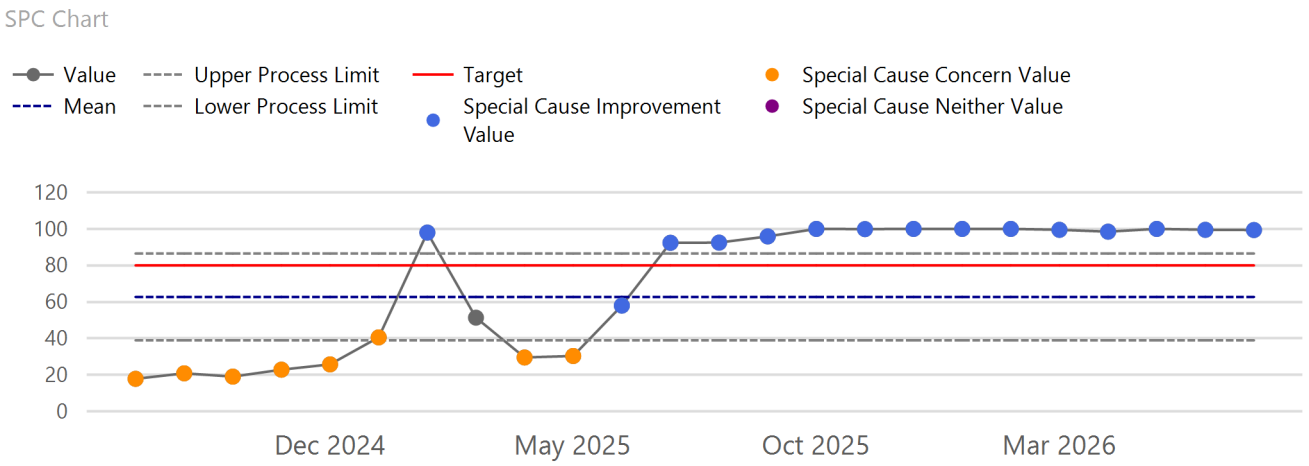
Concerns

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
July 2026	99.4	80	?	H	Chief Operating Officer



Narrative

Consistently exceeding the target

Actions and Owners

Internal flexibility to ensure sufficient assessments are completed

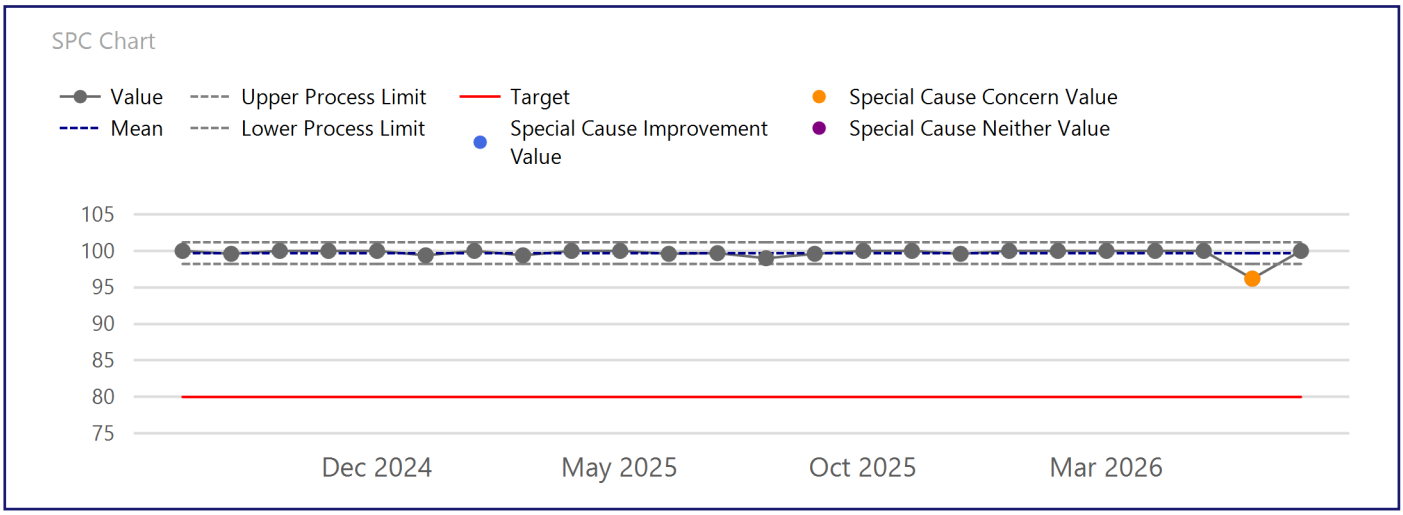
Concerns

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
July 2026	100	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

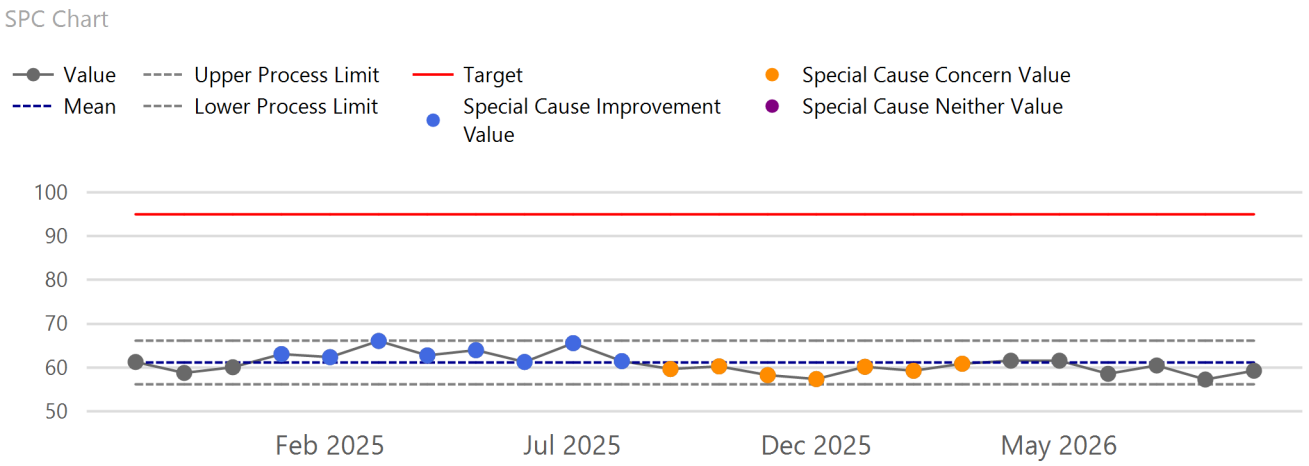
Concerns

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
September 2026	59.3	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.

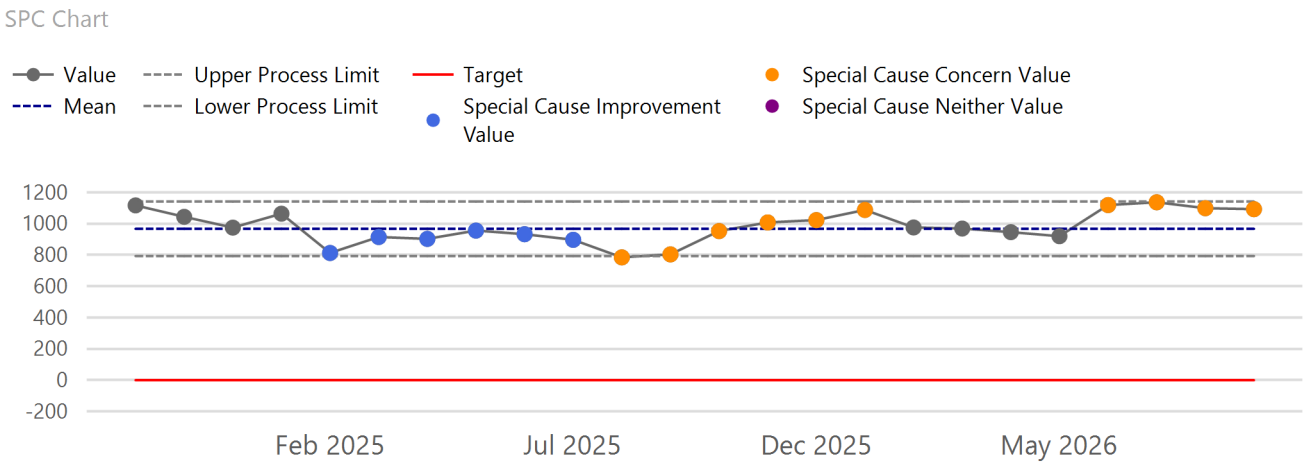
Concerns

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
September 2026	1093	0	F	H	Chief Operating Officer



Narrative

No meaningful changes through the year but increases noted during periods of operational pressures, including past 4 months. 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.
Operational reset in October

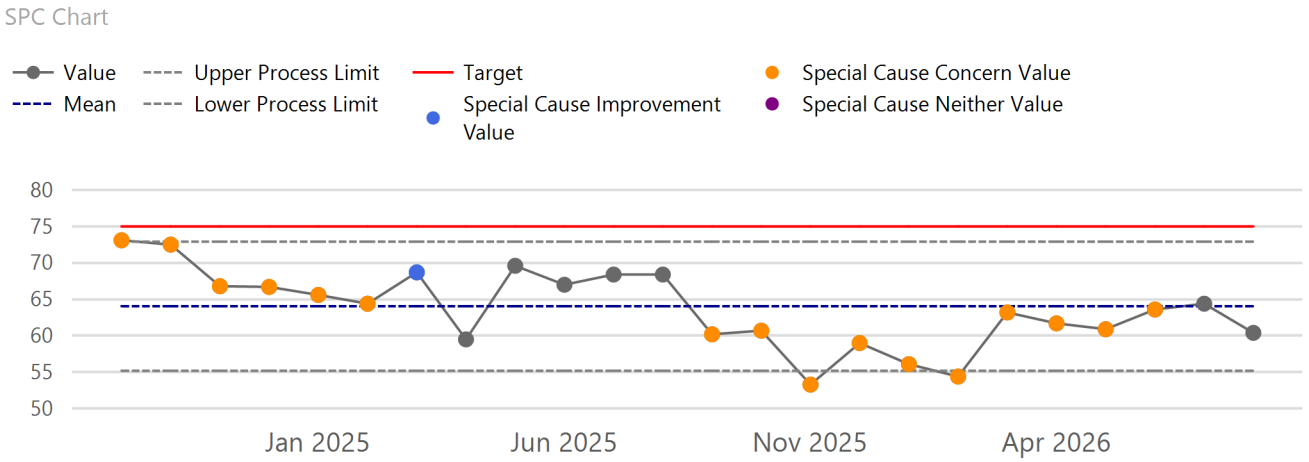
Concerns

Increased breach numbers 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
August 2026	60.4	75	F		Chief Operating Officer



Narrative

Growth in the 62 day backlog and a reduction in SCP performance from August 2025 to February 2026

Maintained over 60% compliance since March 2026 following stabilisation of the skin waiting list with rebalanced capacity

We are not meeting the SCP standard of 75%

Actions and Owners

Trajectory to achieve SCP 75% compliance by Q4 underpinned by actions in key tumour sites:
Upper GI - Locum starting in July with 5 Consultants joining in Q2/Q3
Urology - new consultant post starting August
Skin - Specialty doctor and fellow recruitment in July, conversion of FU outpatient slots to cancer, working group development to review referral process
Review and update of Cancer governance structure/process. Demand and capacity exercise underway for 27/28

Concerns

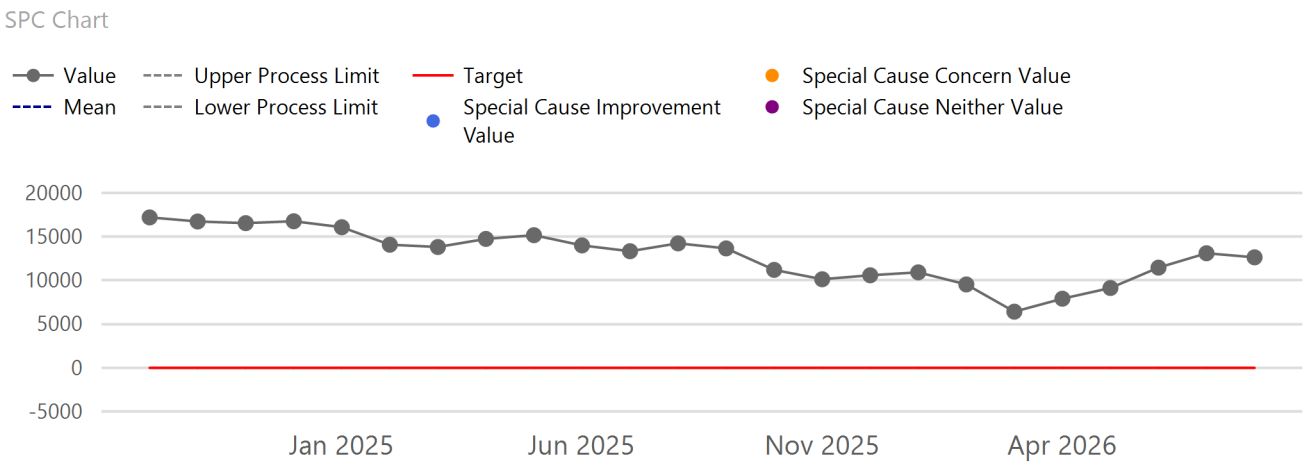
Increase in demand and total waiting list volume

Growth in backlog of patients waiting over 62 days for treatment

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
August 2026	12644	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, NOUS and Endoscopy. The reduction in August was as a result of improvement in the NOUS position

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 has been developed with NHSP&I colleagues to secure investment for further diagnostic capacity.

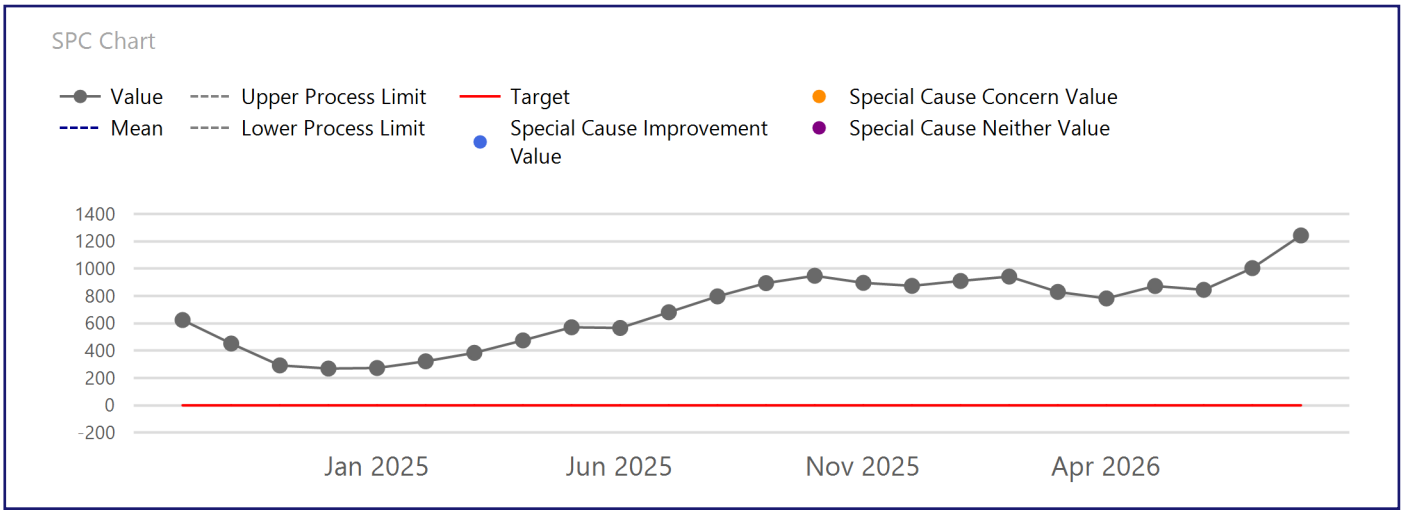
Concerns

Endoscopy and Radiology capacity

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
August 2026	1243	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

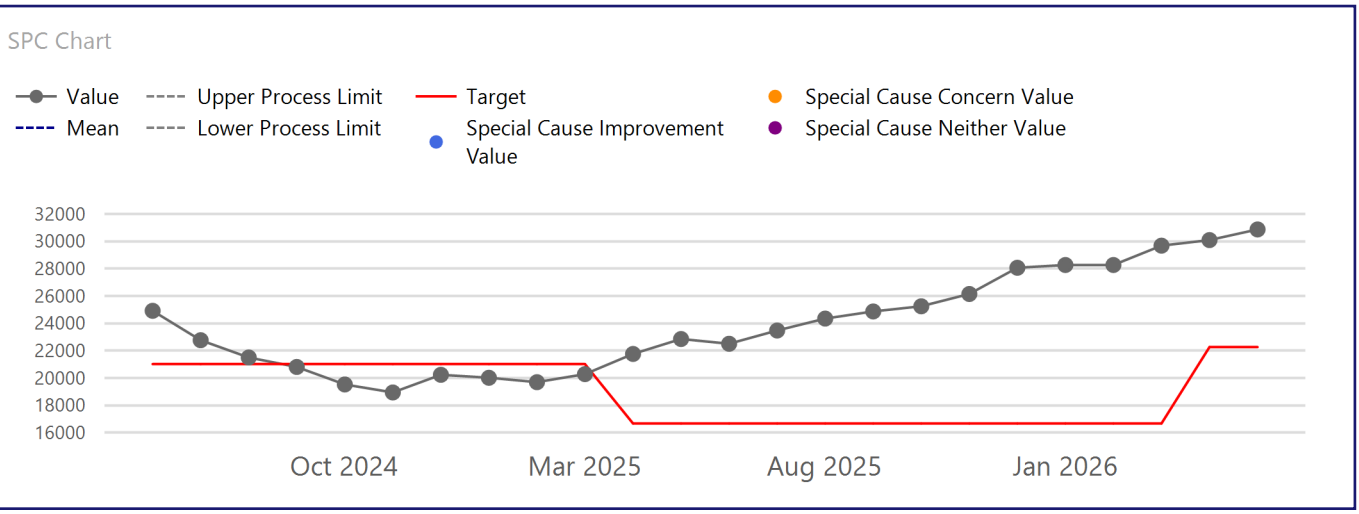
Concerns

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
May 2026	30870	22261	F		Chief Operating Officer



Narrative

Number of delays increased through 25/26

Actions and Owners

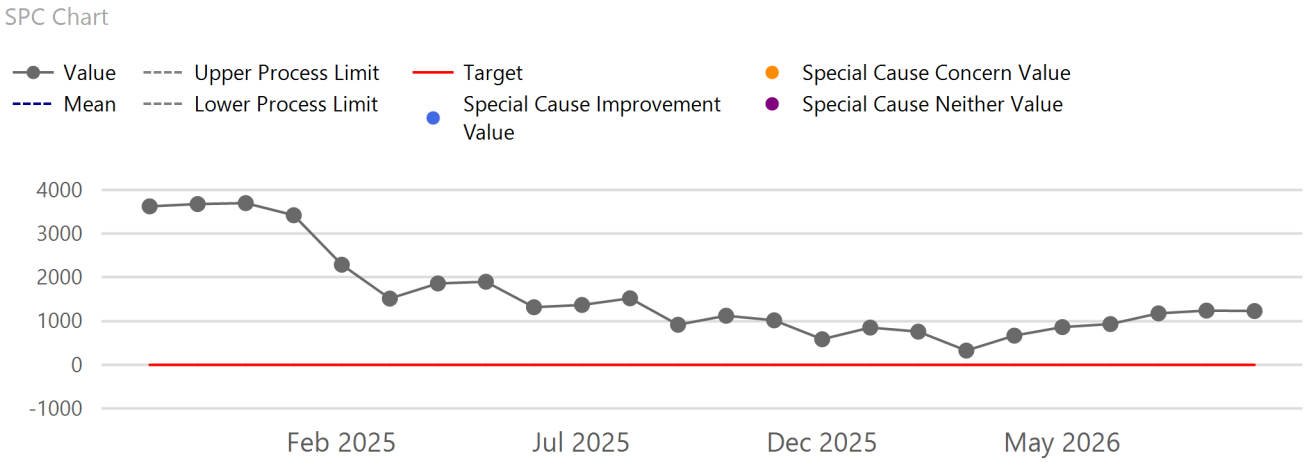
Conversion of unbooked, long waiting follow-ups to SOS/PIFU pathways in selected specialties. This will allow those patients needing follow-up to access an appointment in a timely manor through the see-on-symptoms and patient-initiated follow-up models

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
September 2026	1232	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.

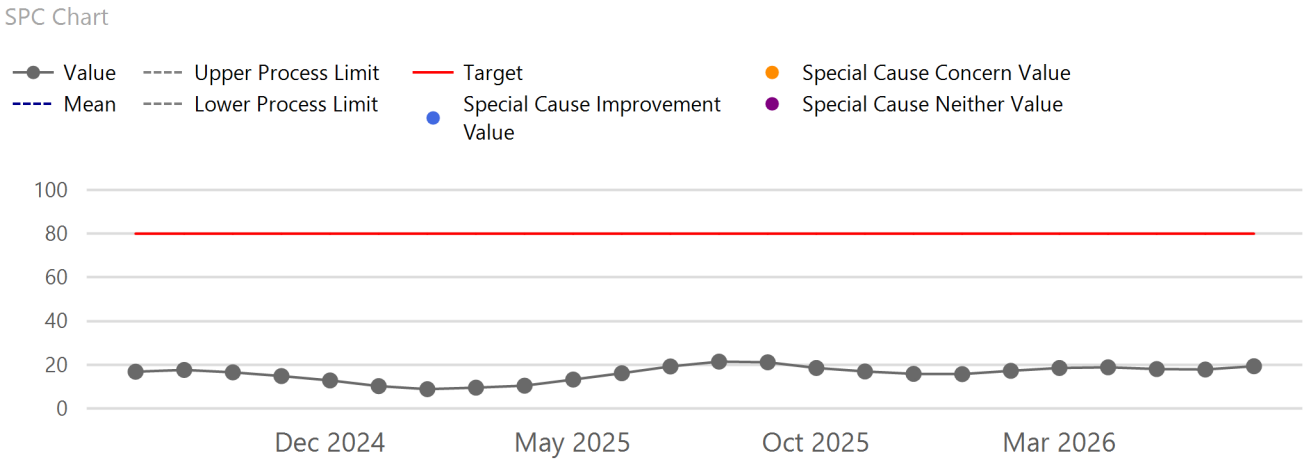
Concerns

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
July 2026	19.4	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

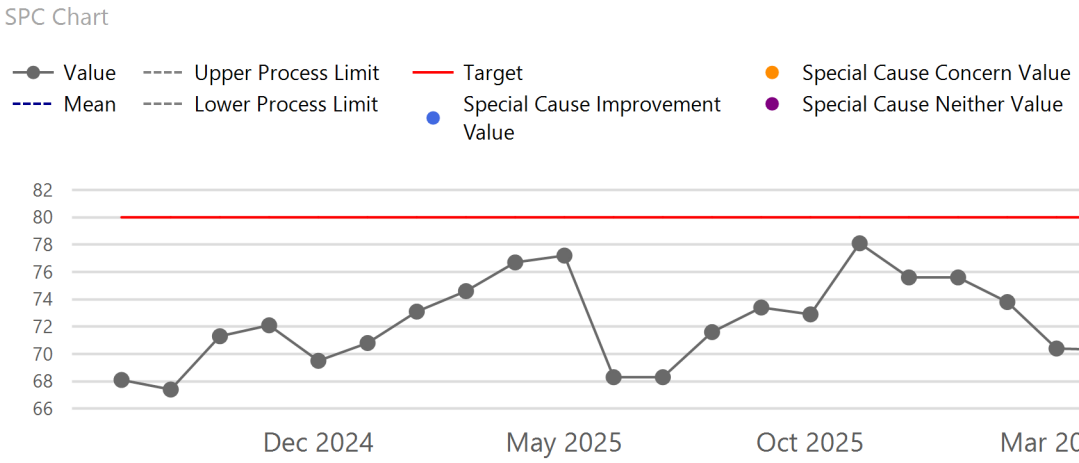
Concerns

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
July 2026	75.7	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

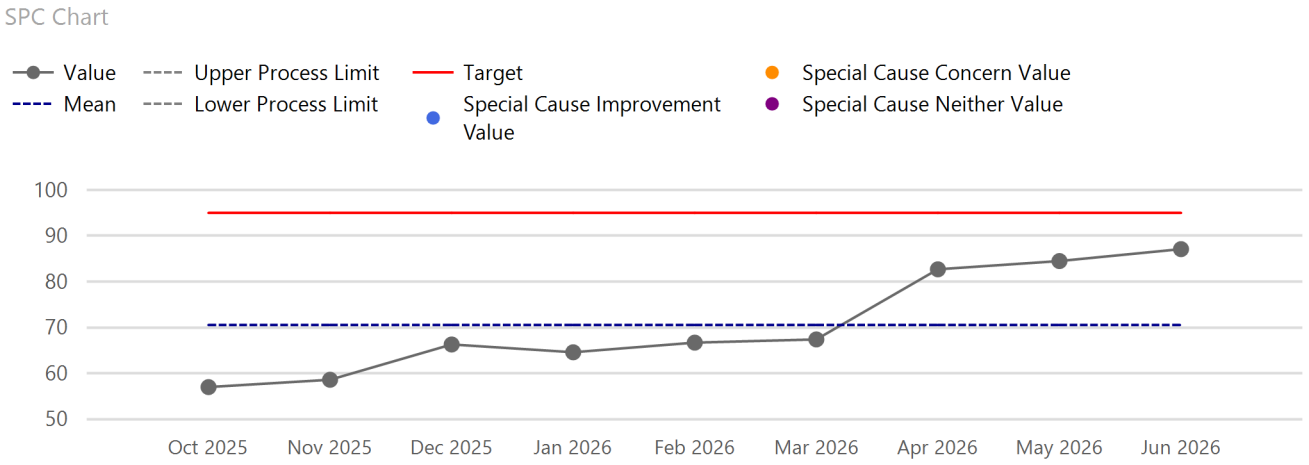
Concerns

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
June 2026	87.1	95			Chief Operating Officer



Narrative

Performance remains below the required target; however, sustained improvement has been achieved over the past two years.

Actions and Owners

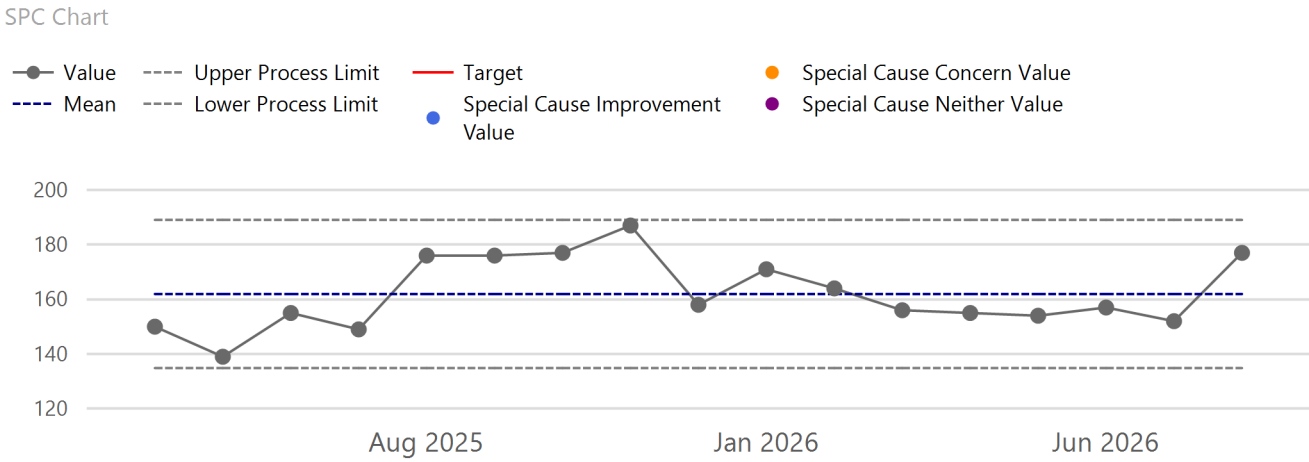
Recent improvements have been supported by enhanced staff retention, productivity improvements across the service, and the strategic deployment of a small number of highly experienced agency coders to supplement the establishment, strengthen skill mix and support ongoing service delivery.
Sustainable 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
August 2026	177				Chief Operating Officer



Narrative

August saw an expected increase in overall numbers of POCD, although total bed days lost is reduced from this month last year. The average days delayed in August was 52

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

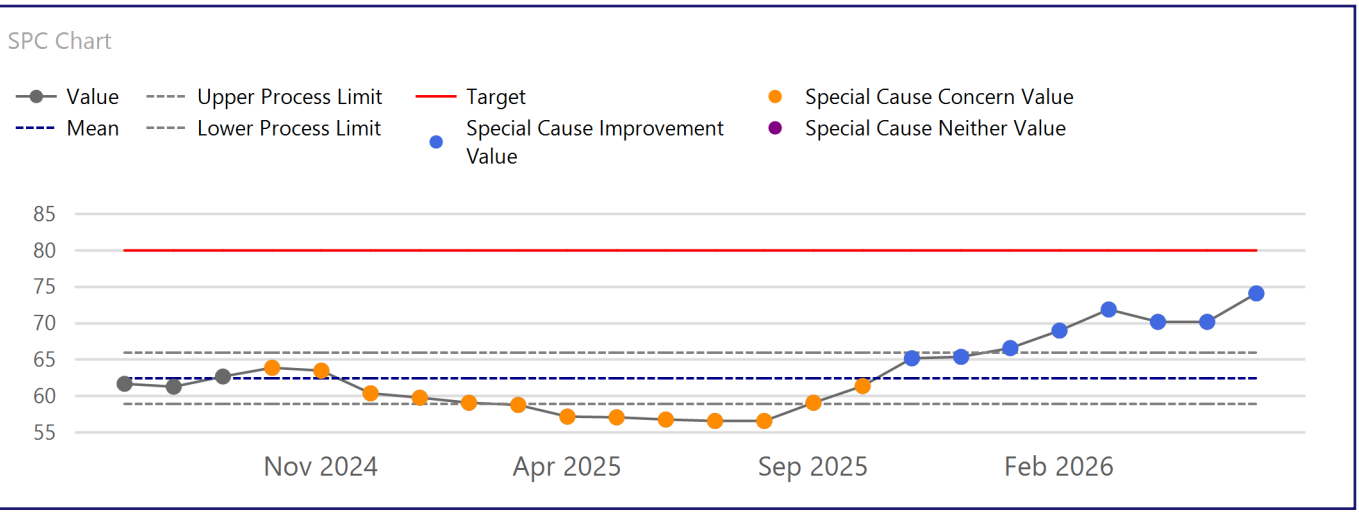
Concerns

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	74.1	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

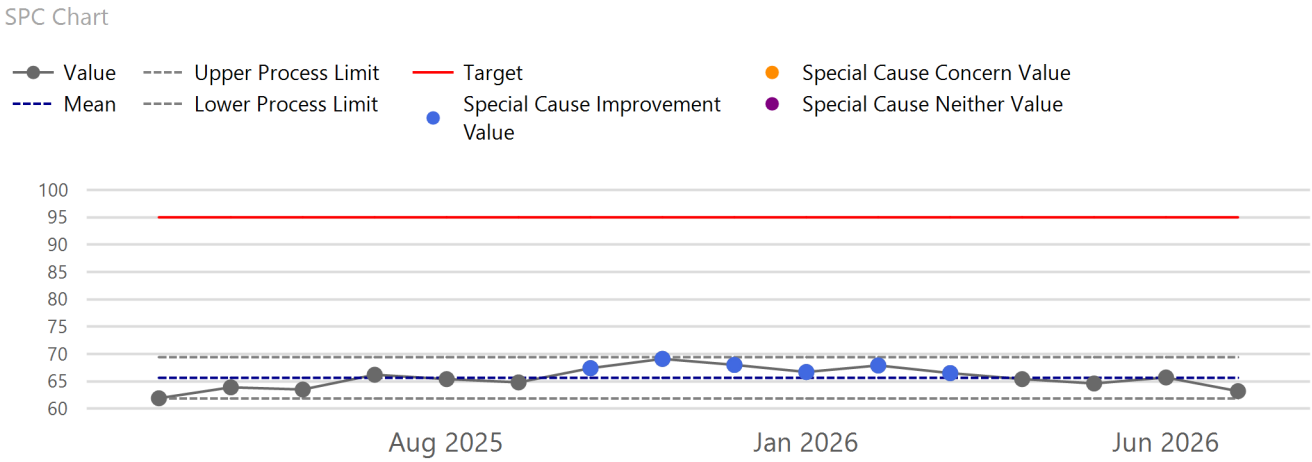
Concerns

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
July 2026	63.2	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.

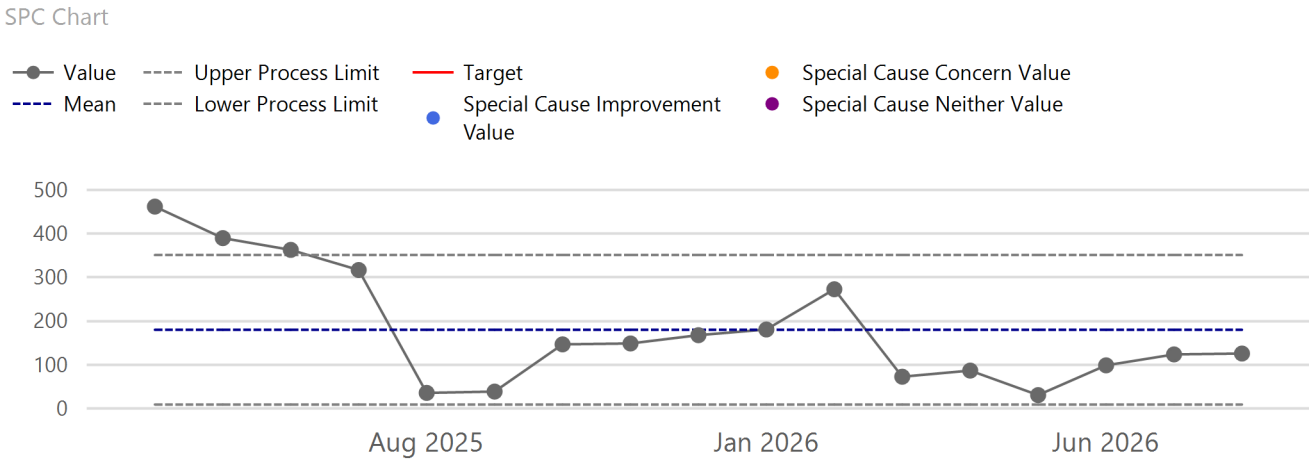
Working with Primary Care on pathway for Diabetic patients to reduce lower grade referrals and free capacity to see urgent patients in a more timely manner

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	126				Chief Operating Officer



Narrative

Old measure - replaced with 45 minute handovers

Actions and Owners

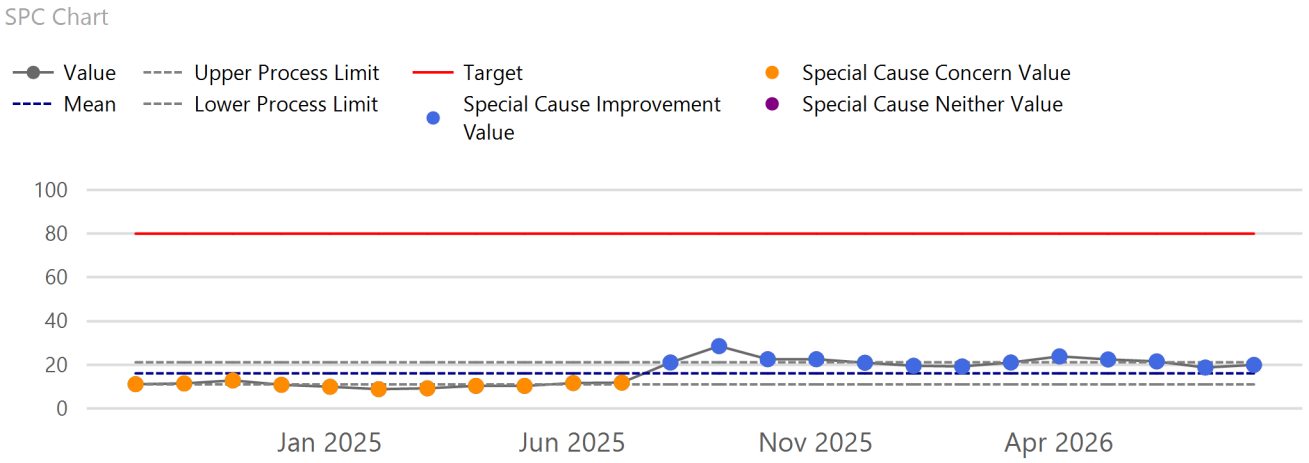
Old measure - replaced with 45 minute handovers

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
August 2026	20	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

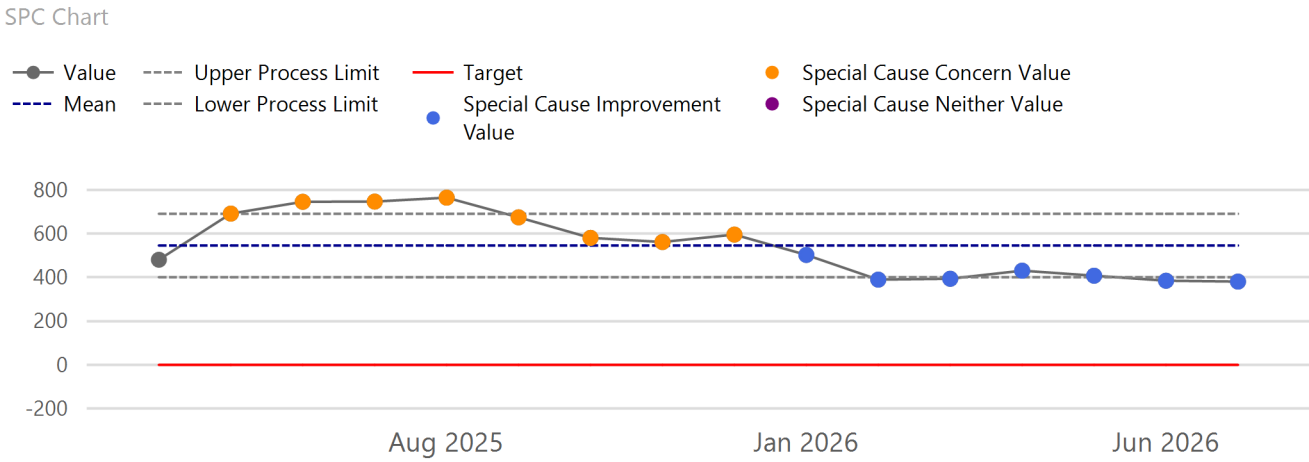
Concerns

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
July 2026	381	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

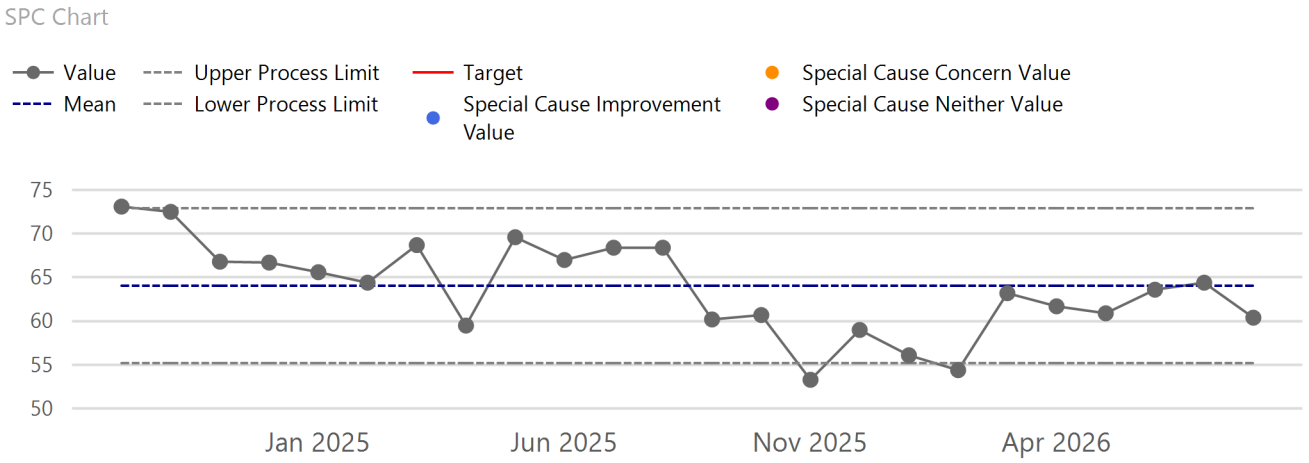
Concerns

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
August 2026	60.4				Chief Operating Officer



Narrative

Growth in the 62 day backlog and a reduction in SCP performance from August 2025 to February 2026

Maintained over 60% compliance since March 2026 following stabilisation of the skin waiting list with rebalanced capacity

We are not meeting the SCP standard of 75%

Actions and Owners

Actions in key tumour sites:
Upper GI - Locum starting in July with 5 Consultants joining in Q2/Q3
Urology - new consultant post starting August
Skin - Specialty doctor and fellow recruitment, conversion of FU outpatient slots to cancer, working group development to review referral process
Review and update of Cancer governance structure/process. Demand and Capacity modelling for 27/28 underway

Concerns

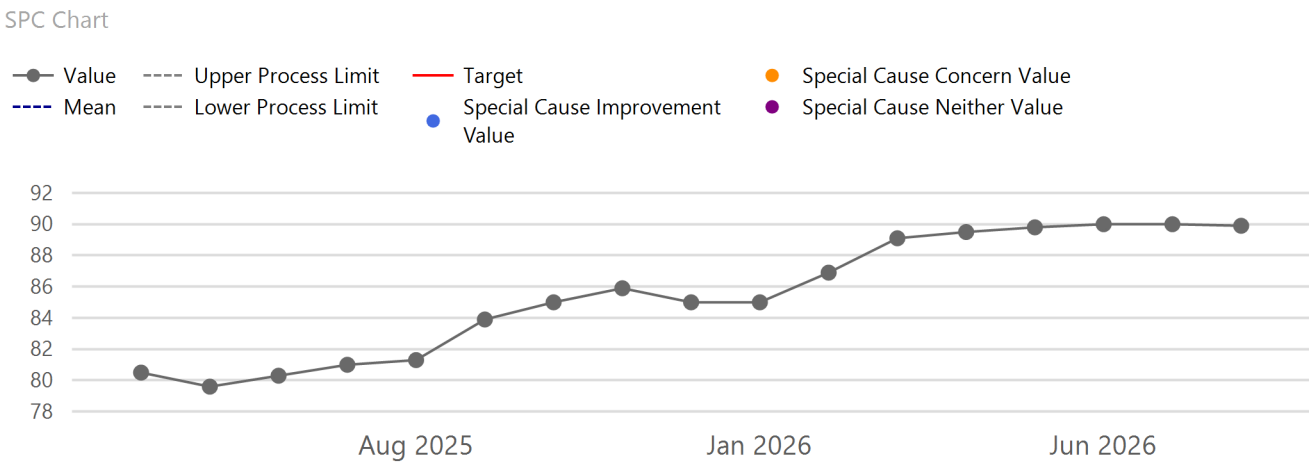
Increase in demand and total waiting list volume

Growth in backlog of patients waiting over 62 days for treatment

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
August 2026	89.9				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

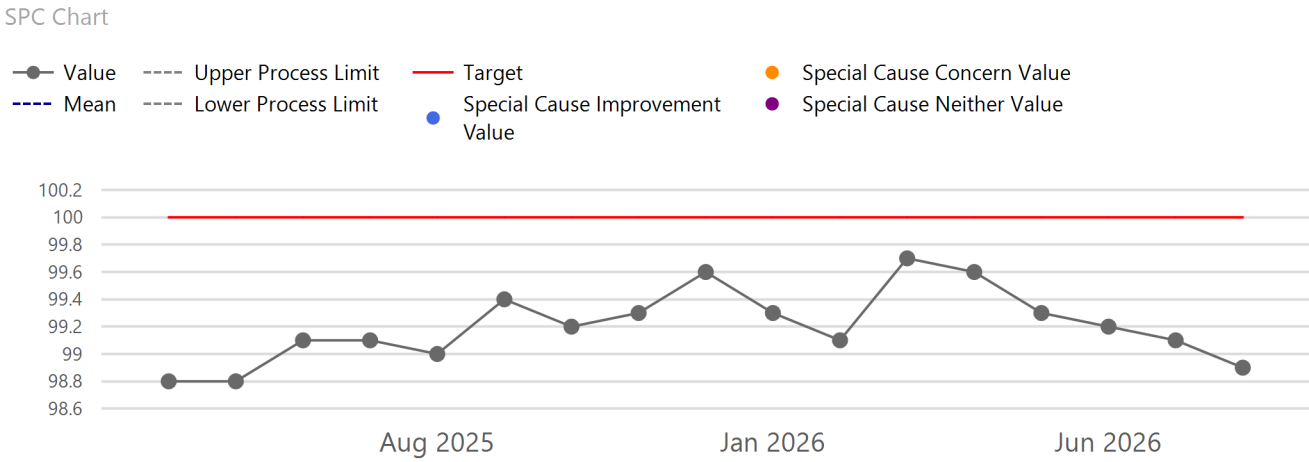
Actions and performance monitored through the newly establish Productivity and Efficiency Board

Concerns

Increase in the number of preaches 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
August 2026	98.9	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

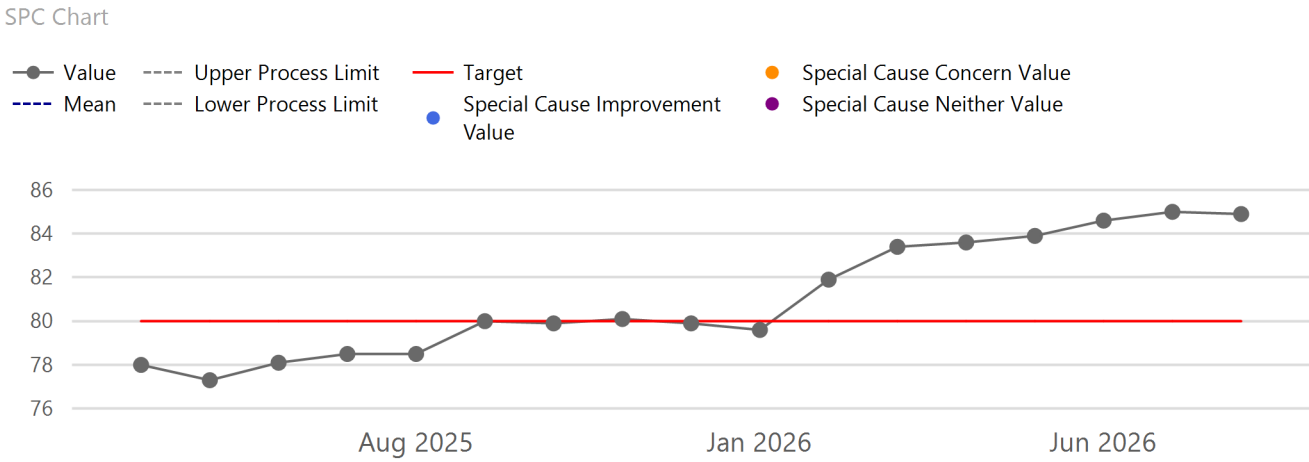
In line with the most recent correspondence from Welsh Government regarding funding for planned care recovery, we have developed plans both internally and with regional partners to eliminate 2-years waits in as many specialties as possible across the region. These have been shared with Committee and 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
August 2026	84.9	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.

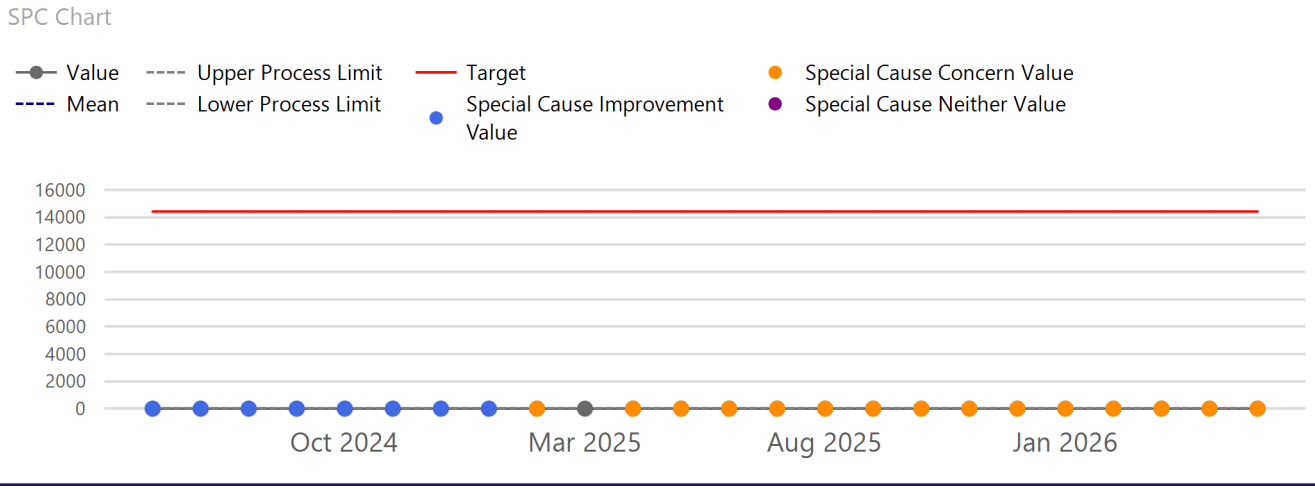
Concerns

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	1	14415	P	H	Chief Operating Officer



Narrative

Consistently exceeding the target

Actions and Owners

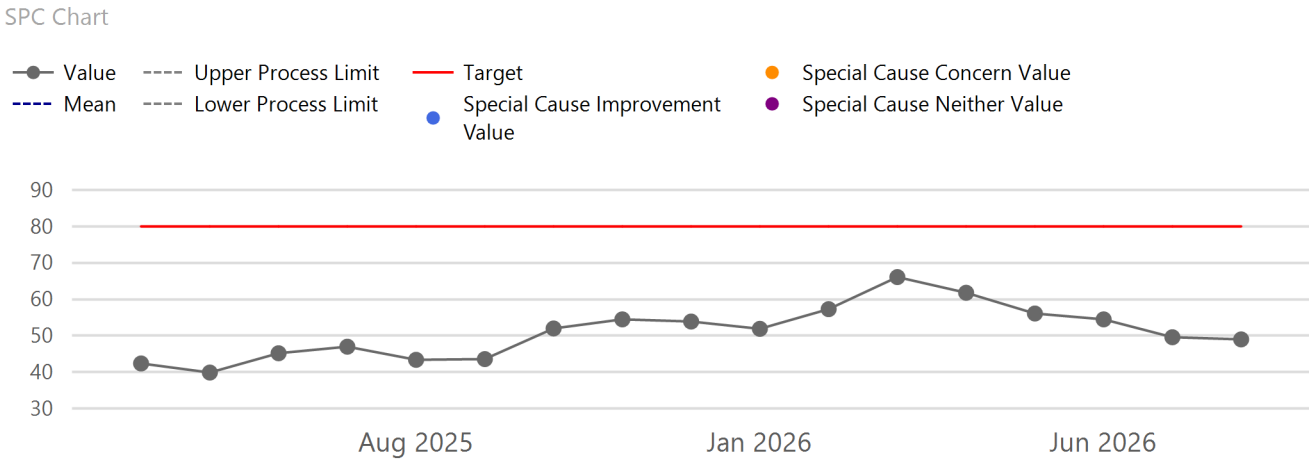
Internal flexibility to ensure sufficient assessments are completed

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
August 2026	49	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. NOUS waits reduced in August, but the volume of 8 week waits remains high

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

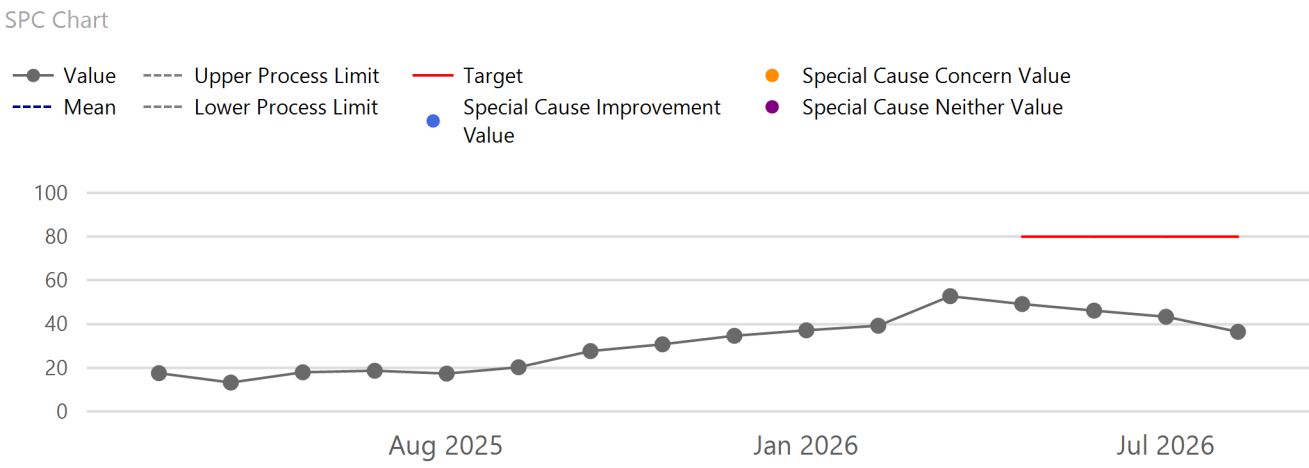
Endoscopy and Radiology capacity

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
August 2026	36.5	80	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

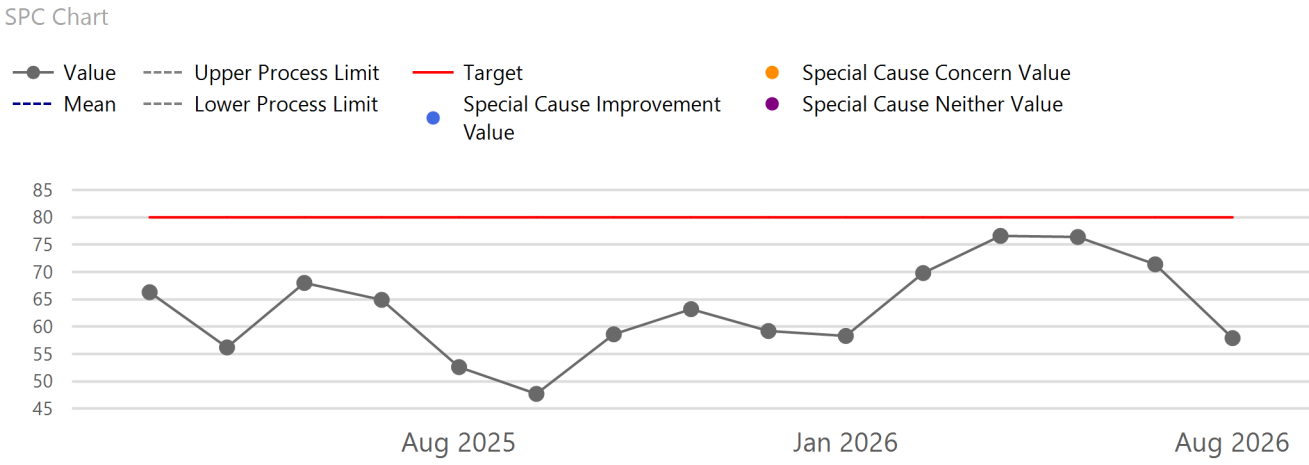
Concerns

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
August 2026	57.9	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.

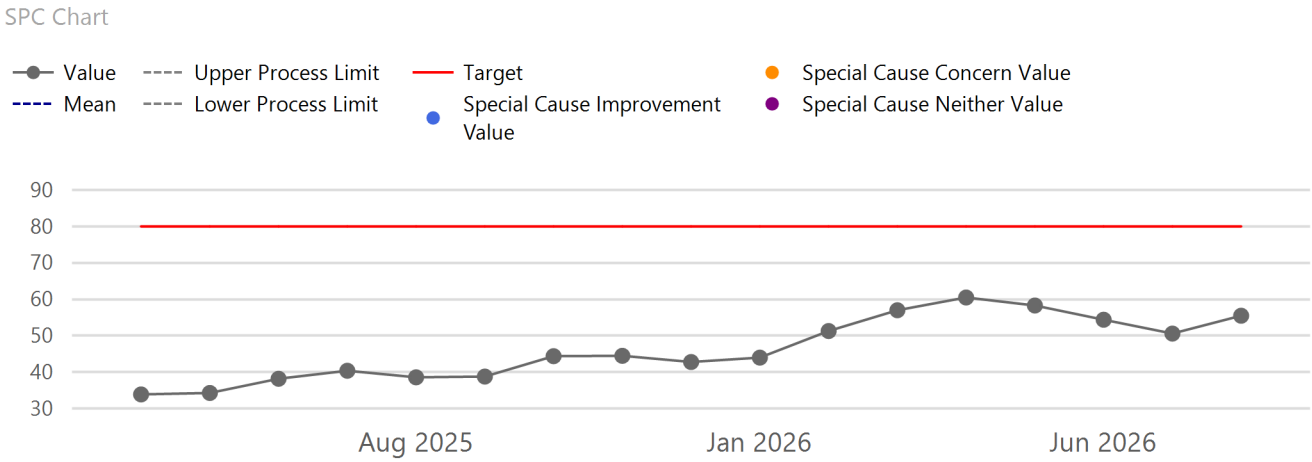
An action plan is being developed with NHSP&I colleagues to secure investment for further diagnostic capacity

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
August 2026	55.5	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.

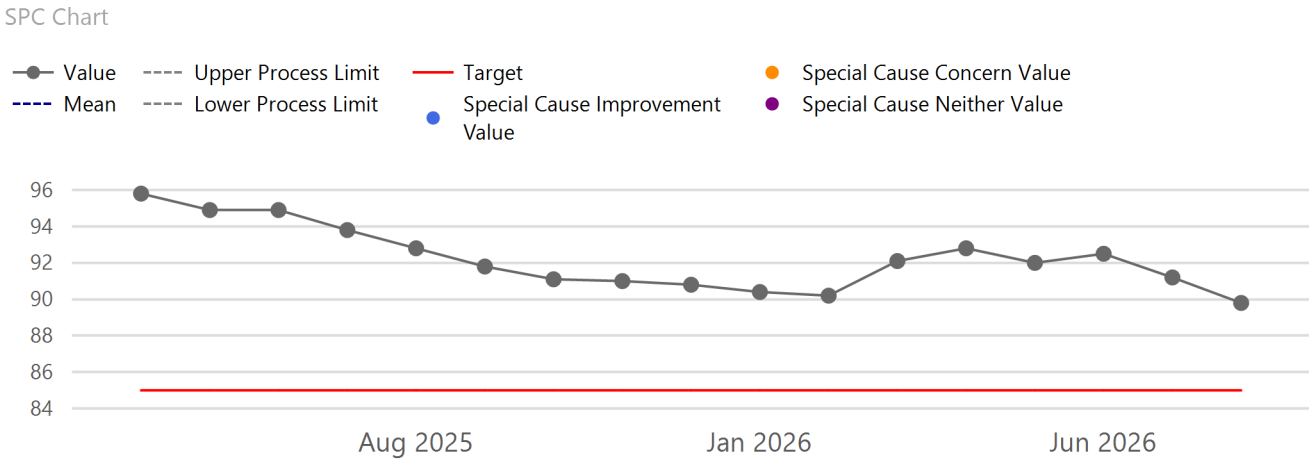
An action plan is being developed with NHSP&I colleagues to secure investment for further diagnostic capacity

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
August 2026	89.8	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

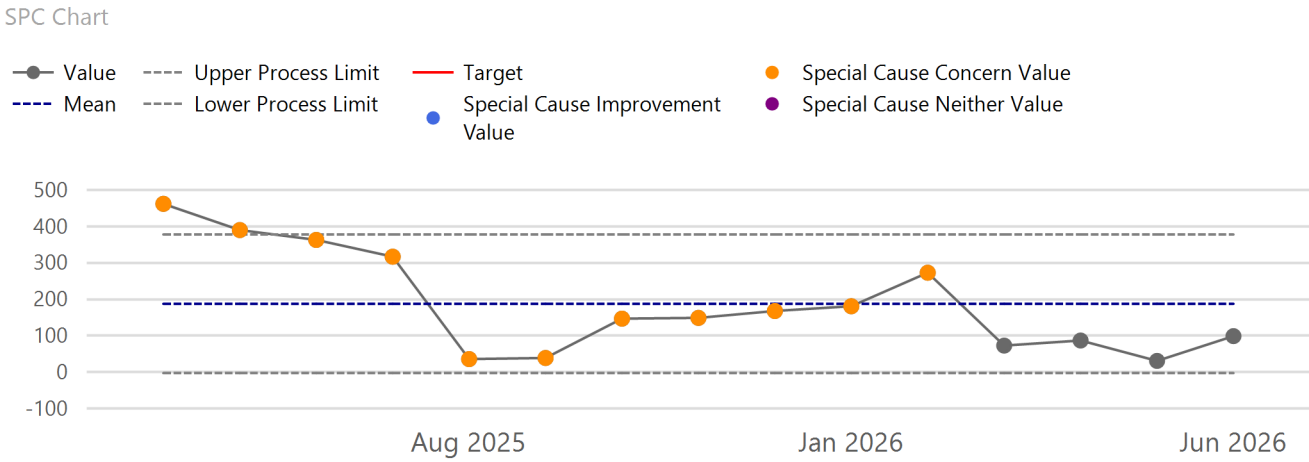
Concerns

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	99				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

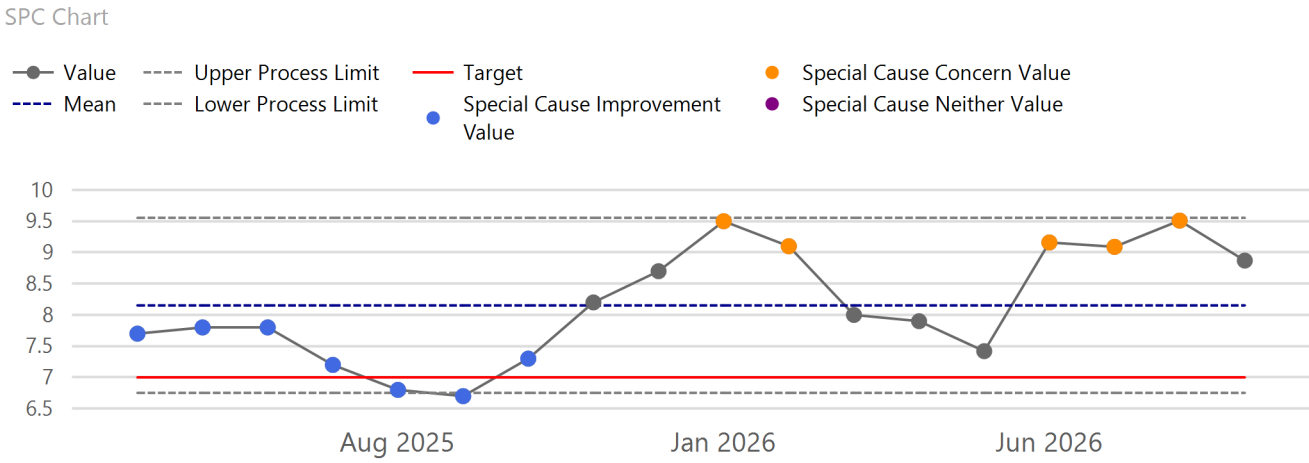
Concerns

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
September 2026	8.87	7			Chief Operating Officer



Narrative

No meaningful changes through the year but increases noted during periods of operational pressures through Q2. 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.
Operational reset, October 2026

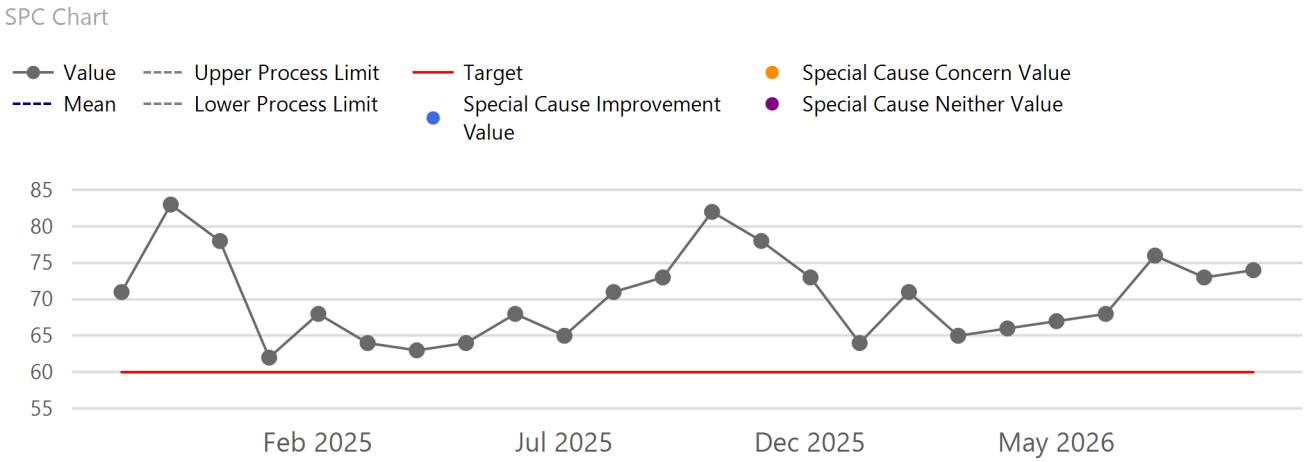
Concerns

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
September 2026	74	60	F		Chief Operating Officer



Narrative

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

Actions and Owners

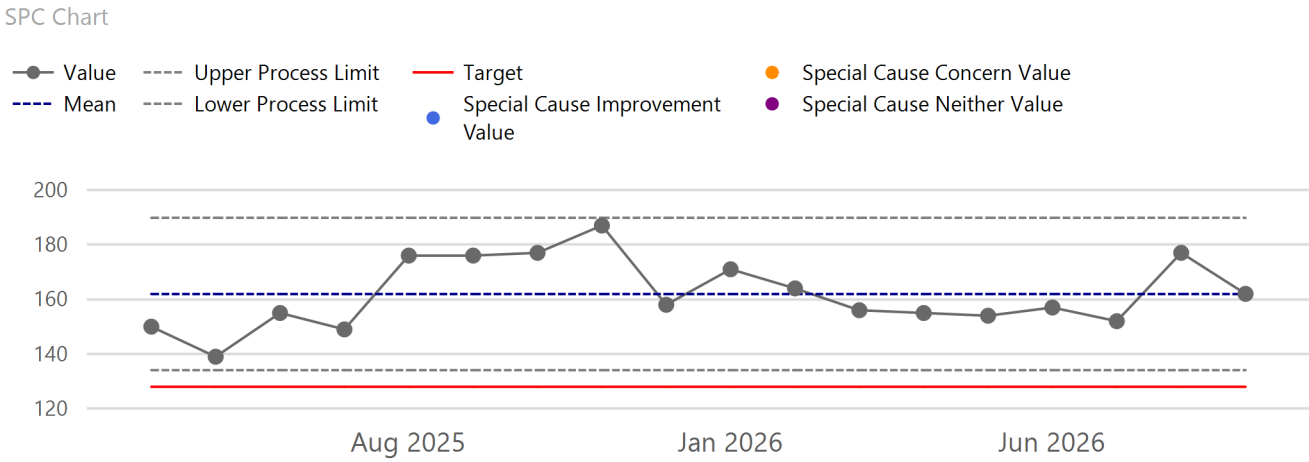
Continued maximisation of MSDEC activity.
Development of SPoA, Safe@Home now incorporated to support alternative to EU attendances.
ACU desk to coordinate timely clinical responses.
Actions and performance metrics monitored through UEC Programme Board.
Operational reset in October

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	162	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

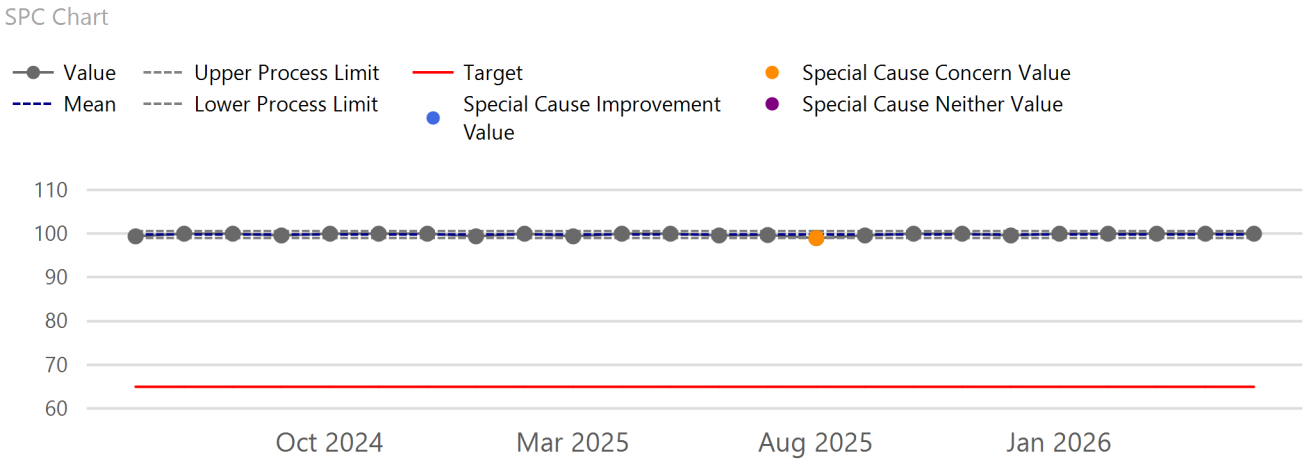
Concerns

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	100	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

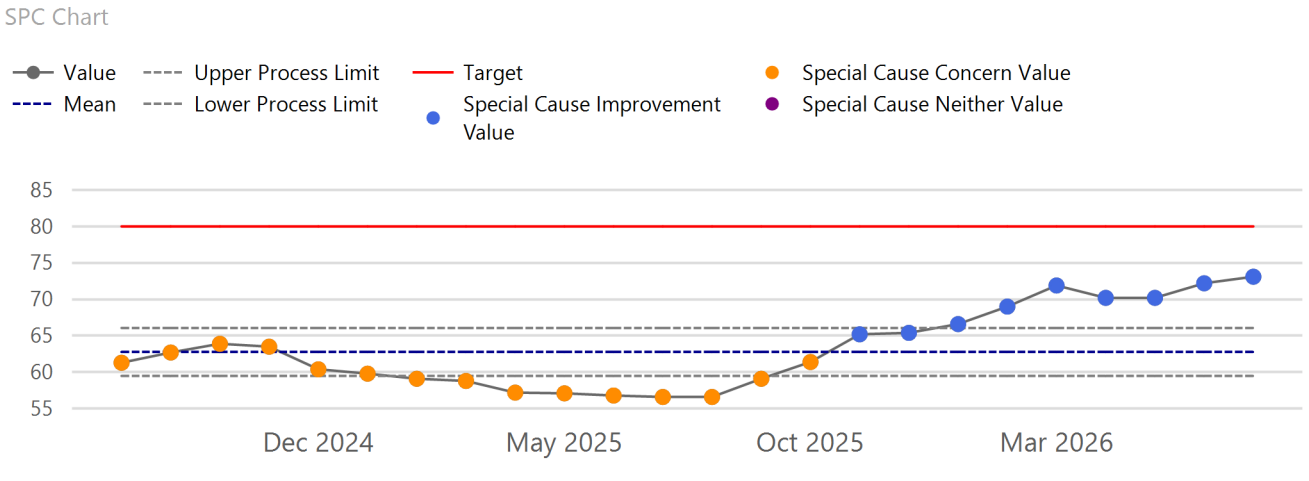
Concerns

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	73.1	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

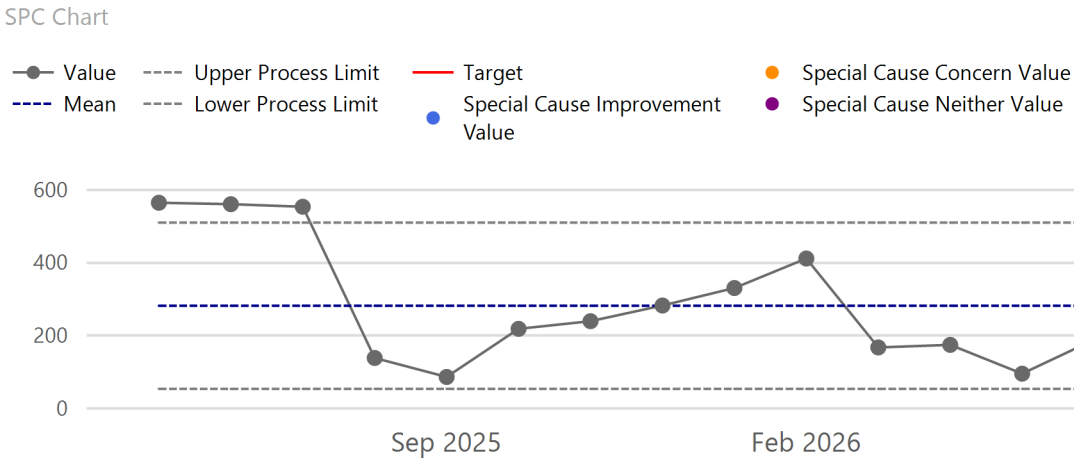
Review and redistribute CTPs across all specialties within the teams.
Monitored through newly developed Power BI dashboard (weekly meetings). Monthly Directorate reviews and monthly Touchpoint with NHSP&I colleagues

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	249				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

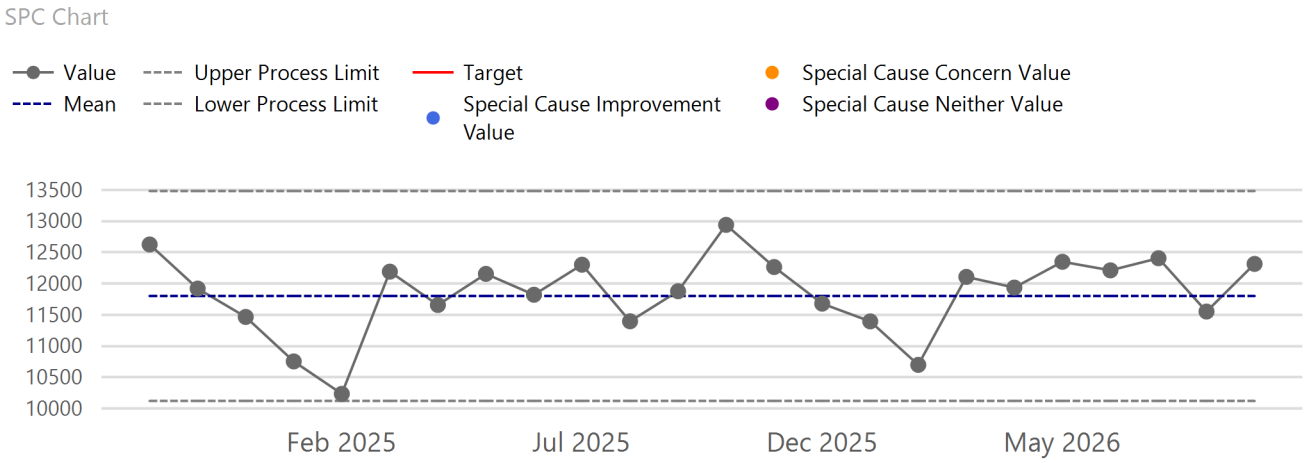
Suite of actions to support EU and flow:
Update and refresh of acute referral policy
Escalation triggers moved to 15 and 30 minutes
ACU desk to coordinate timely clinical responses
Acute physician pull model from ambulatory areas direct to Medical SDEC
Phase 1 of acute remodel - frailty assessment
Actions 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
September 2026	12317				Chief Operating Officer



Narrative

Metric provided for information. The C&V approach for reporting against these measures will be reviewed in Q3

Actions and Owners

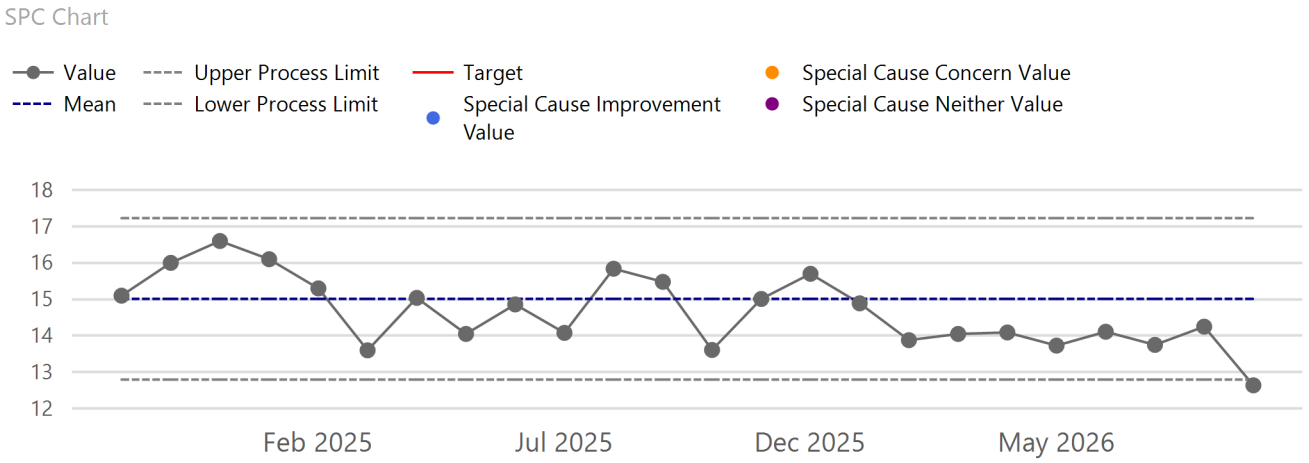
n/a

Concerns

n/a

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

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	12.64				Chief Operating Officer



Narrative

Metric provided for information. The C&V approach for reporting against these measures will be reviewed in Q3

Actions and Owners

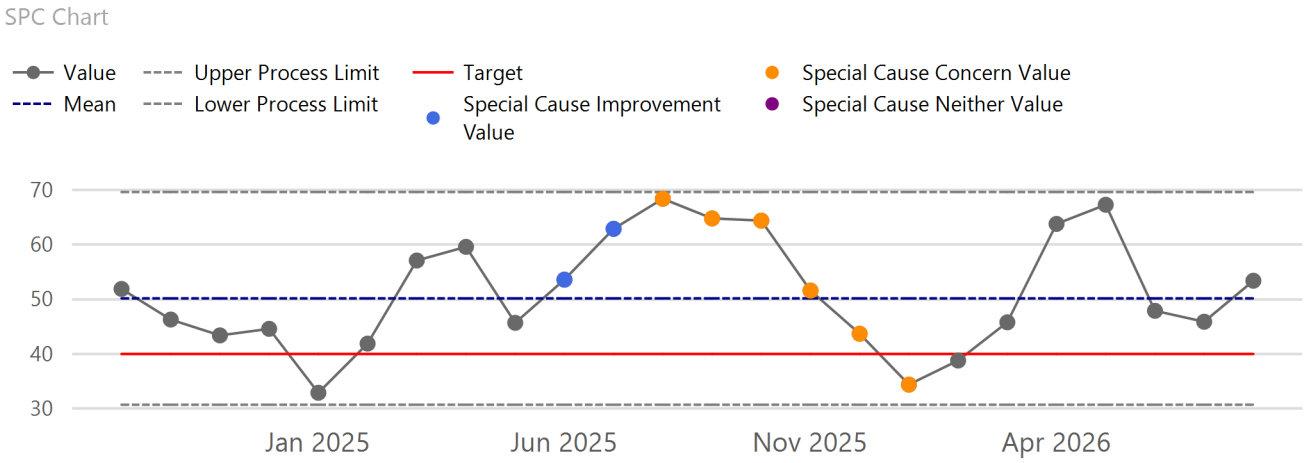
n/a

Concerns

n/a

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

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	53.4	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 increased in August

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

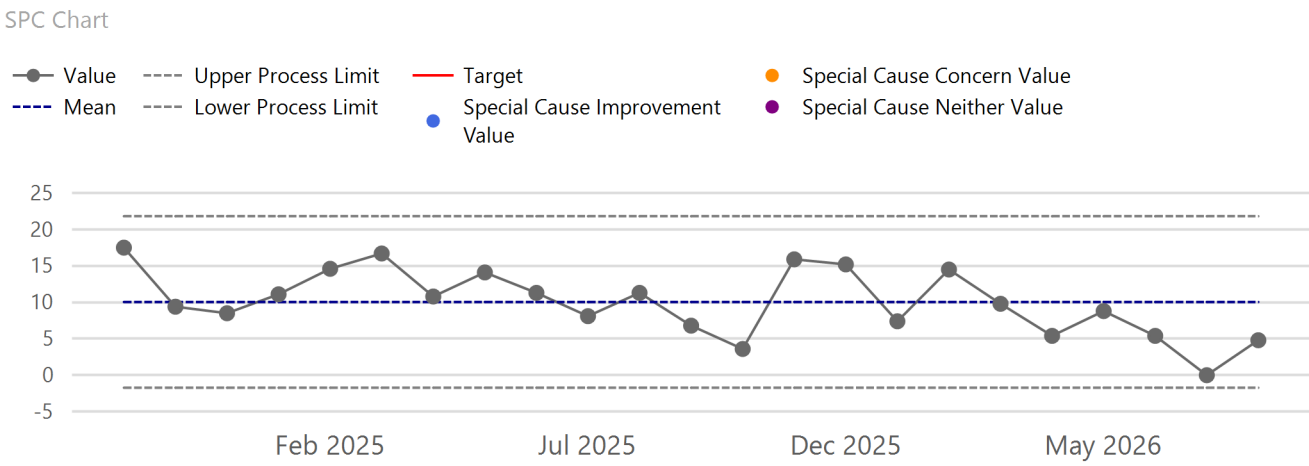
Exec led stocktake in October

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
August 2026	4.8				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

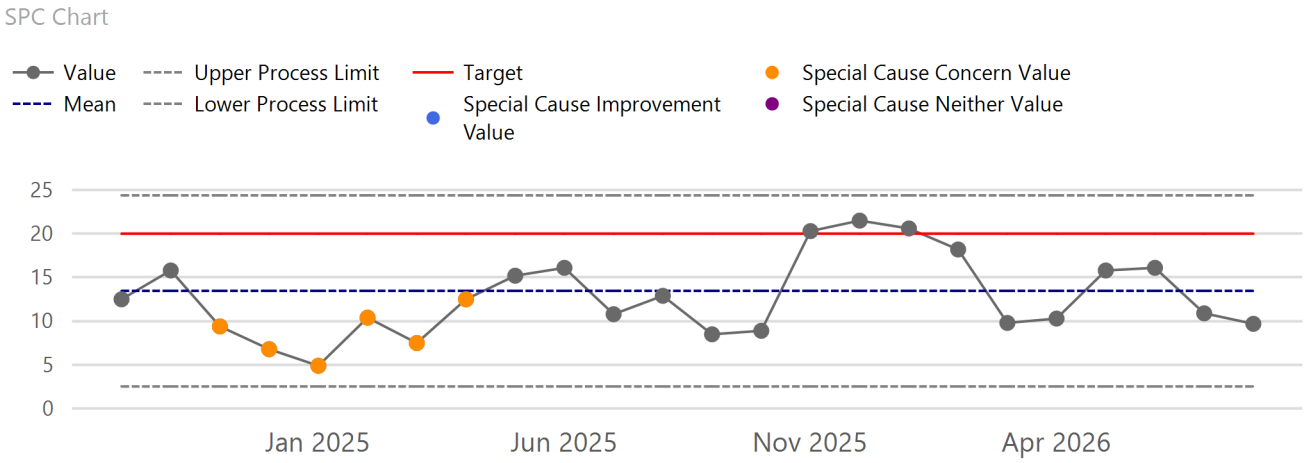
Education plan for all staff involved in stroke pathway being developed

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
August 2026	9.7	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

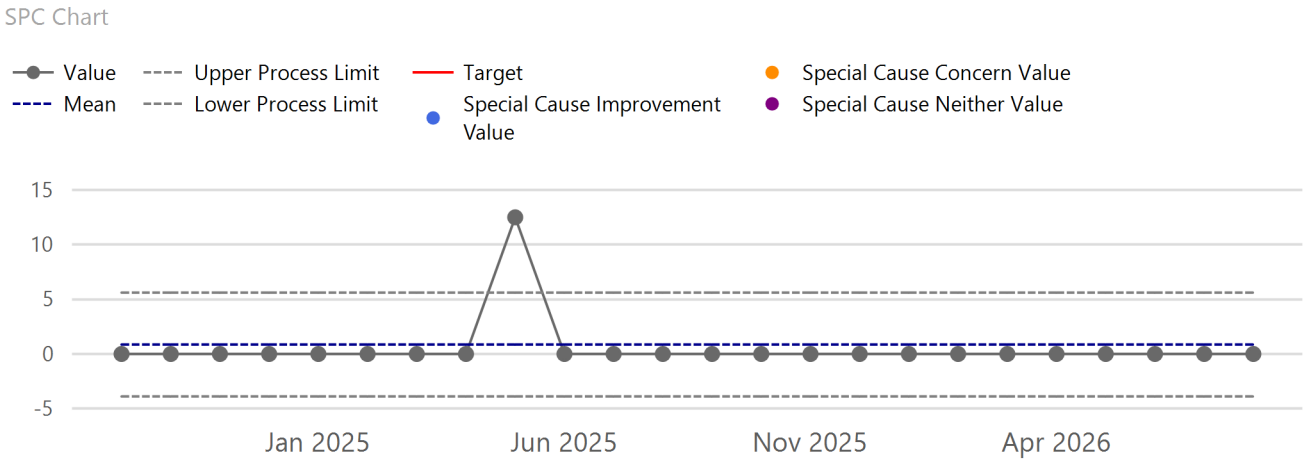
Education plan for all staff involved in stroke pathway being developed

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
August 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

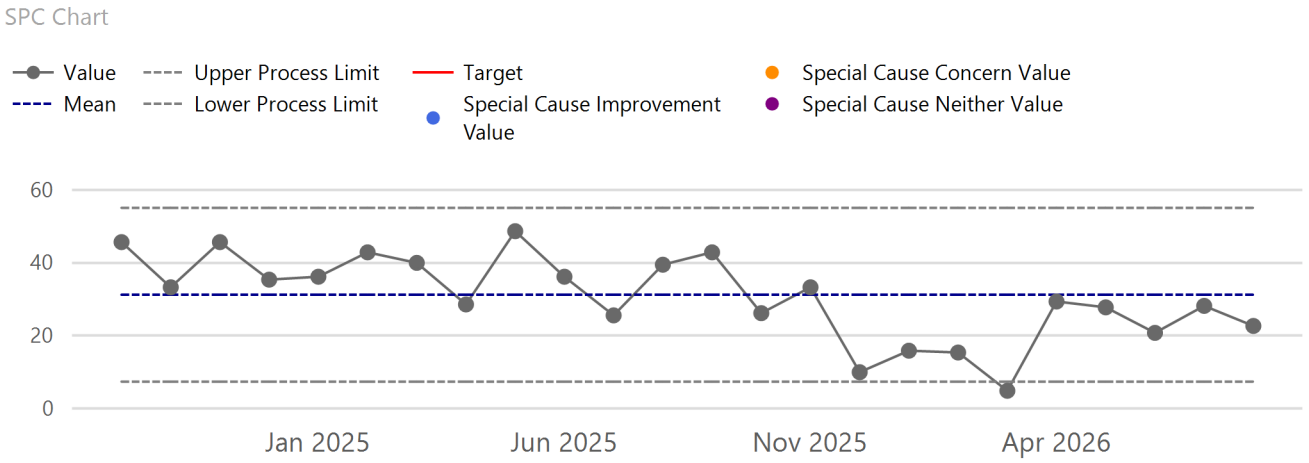
Education plan for all staff involved in stroke pathway being developed

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
August 2026	22.7				Chief Operating Officer



Narrative

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

Actions and Owners

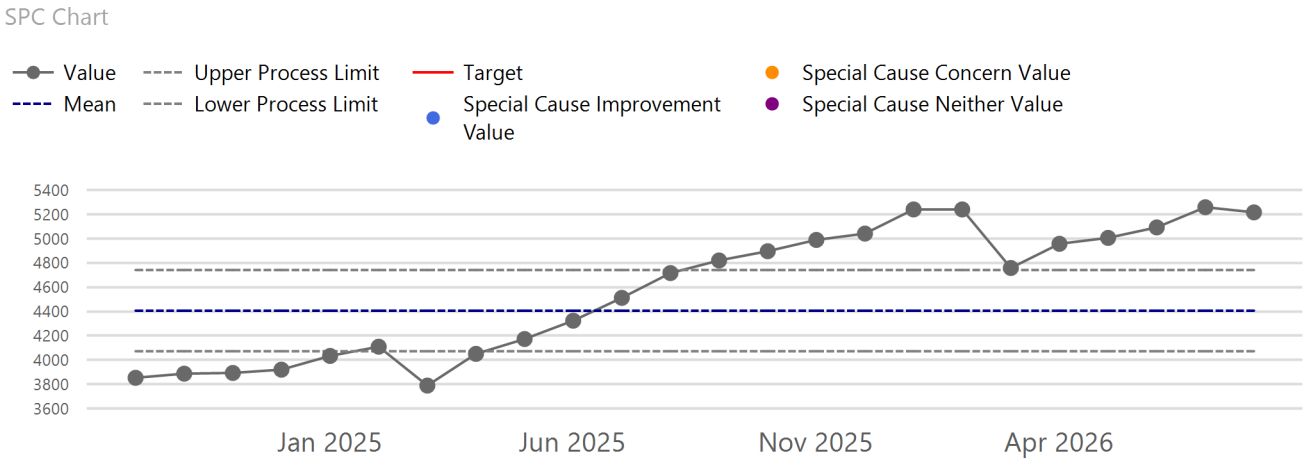
Ringfenced capacity remains
Review into Length of Stay
Mortality review through Q&S

Concerns

Fluctuations in performance

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

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	5216				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

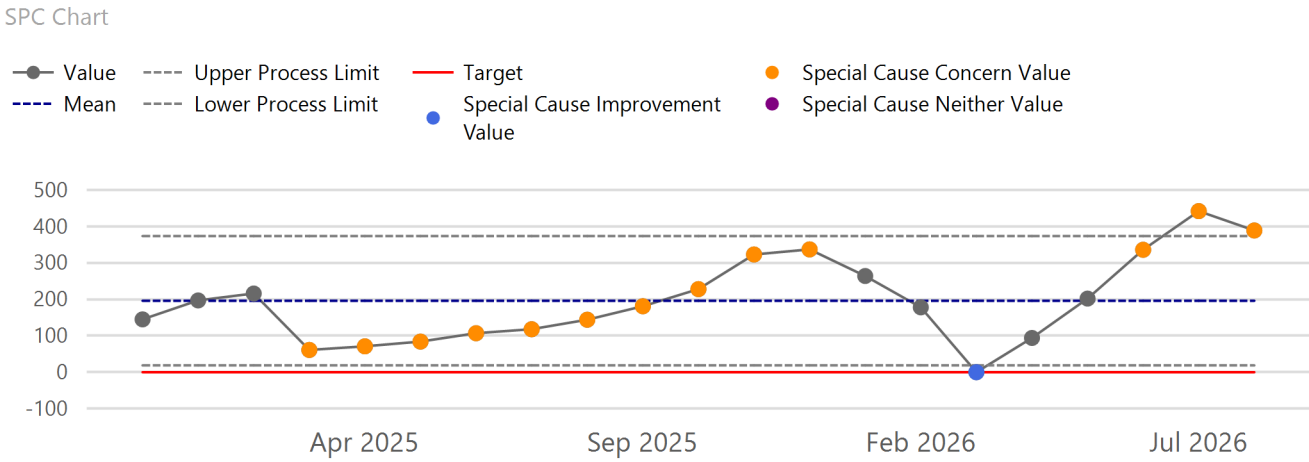
Performance is monitored within the Clinical Board and through the Clinical Board Executive Reviews

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
August 2026	389	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
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-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
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Increased digitisation, including digital platforms for assessments and follow-up appointments
Continued engagement with Education

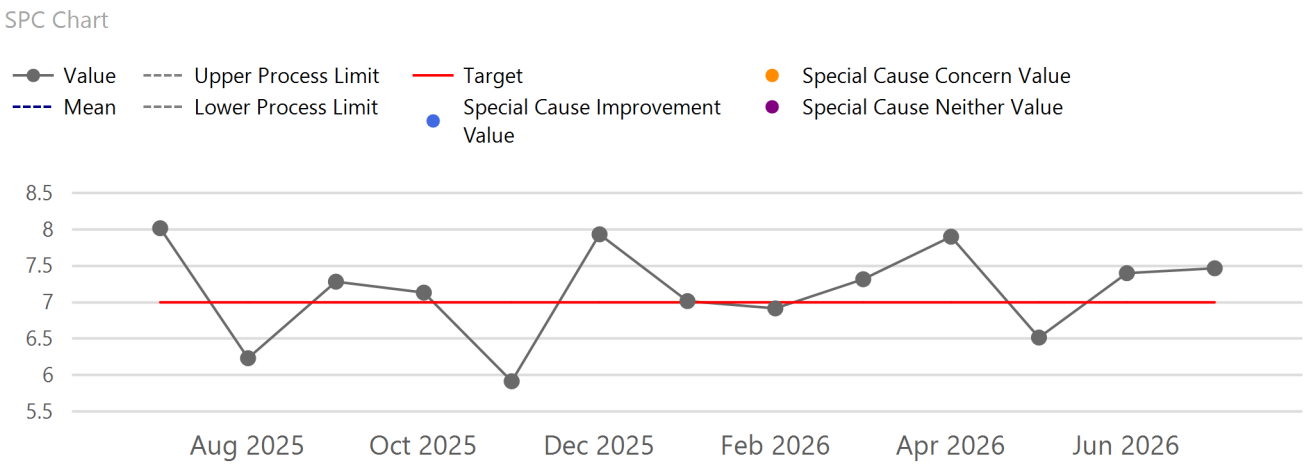
Performance is monitored within the Clinical Board and through the Clinical Board Executive Reviews

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
July 2026	7.467	7	F		Chief Operating Officer



Narrative

This measure is owned by WAST. The C&V approach for reporting against these measures will be reviewed in Q3

Actions and Owners

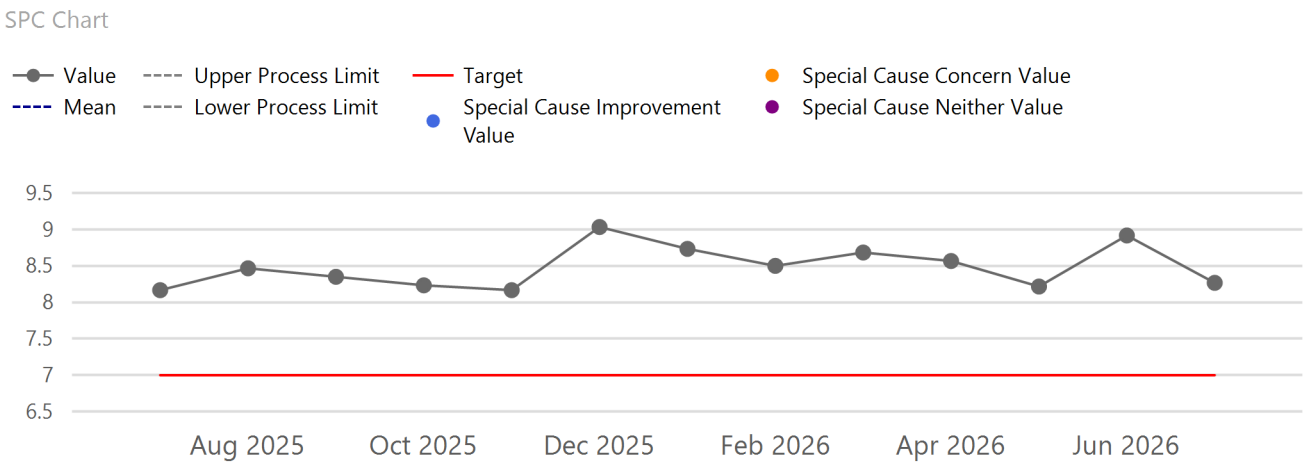
n/a

Concerns

n/a

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

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	8.267	7	F		Chief Operating Officer



Narrative

This measure is owned by WAST. The C&V approach for reporting against these measures will be reviewed in Q3

Actions and Owners

n/a

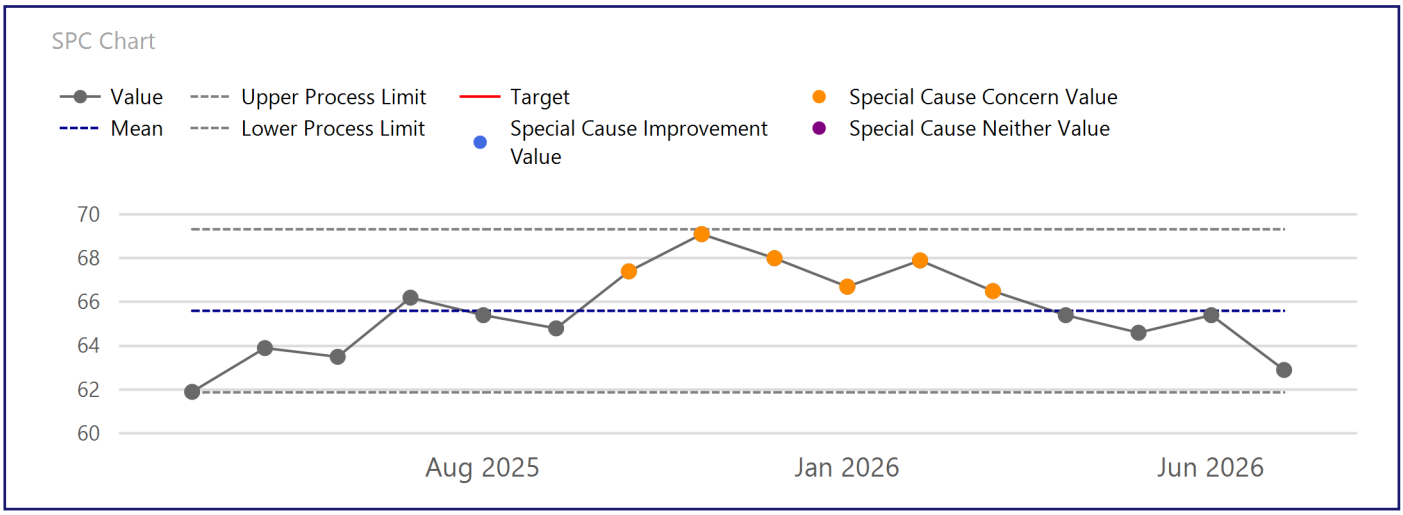
Concerns

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
July 2026	62.9				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

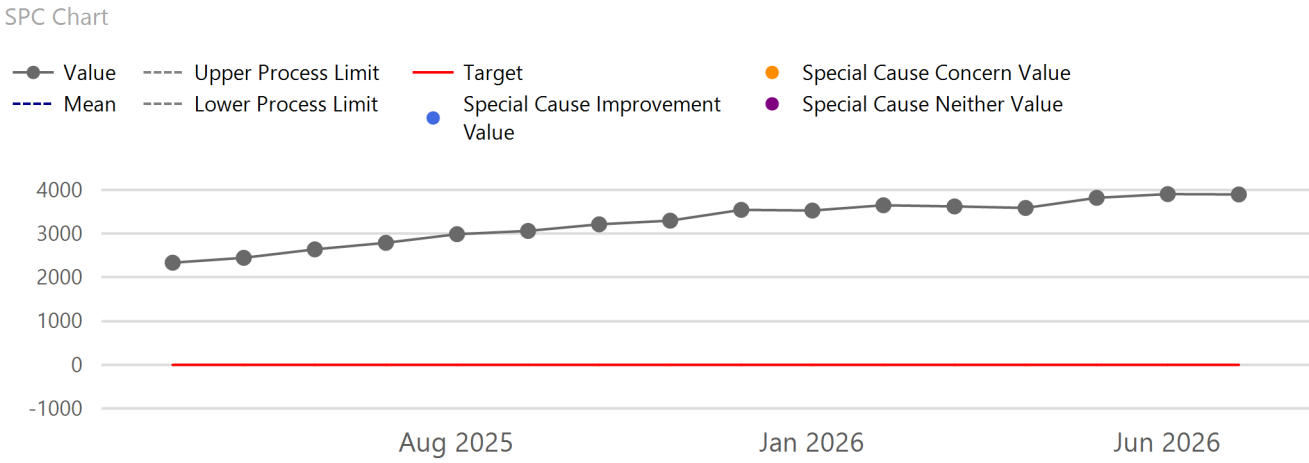
Concerns

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
July 2026	3898	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

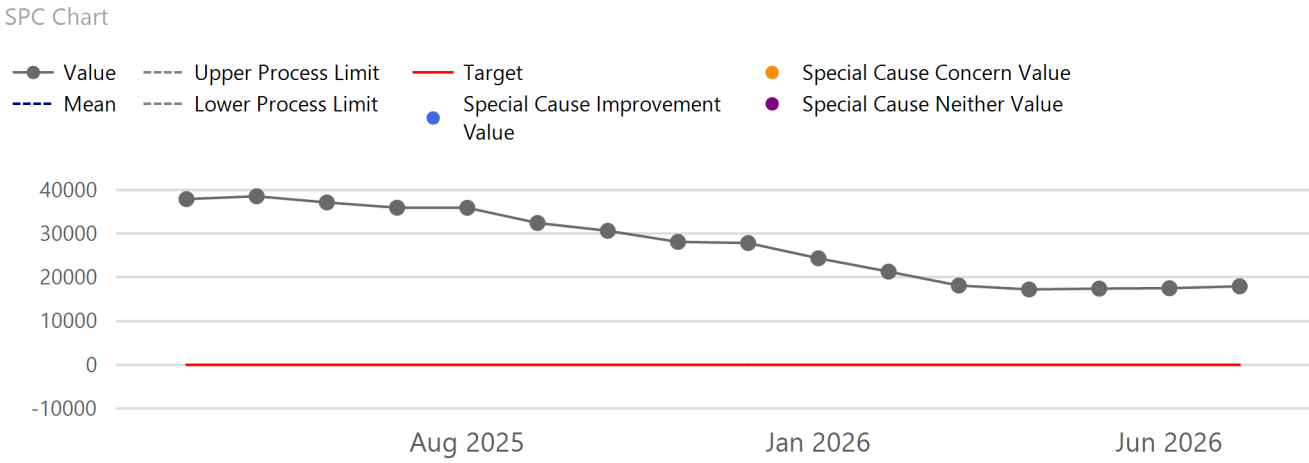
Concerns

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
July 2026	17973	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 maintained this improved position.

The use of SPC charts in not appropriate for the RTT measures - the format for this reporting will be reviewed locally and in line with the national reporting dashboard

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

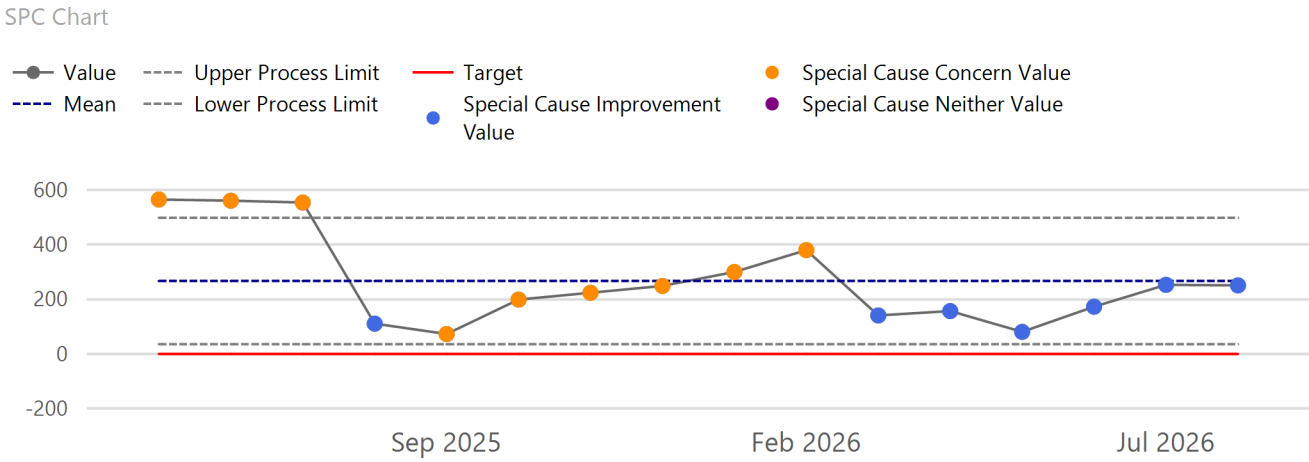
Actions and performance monitored through the newly established Executive Productivity and Efficiency Board

Concerns

Not meeting standard

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

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	251	0	F	L	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 and August. 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. Welsh Government are currently reviewing the reporting criteria for Ambulance delays and we will reflect any changes to the methodology in our reporting

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

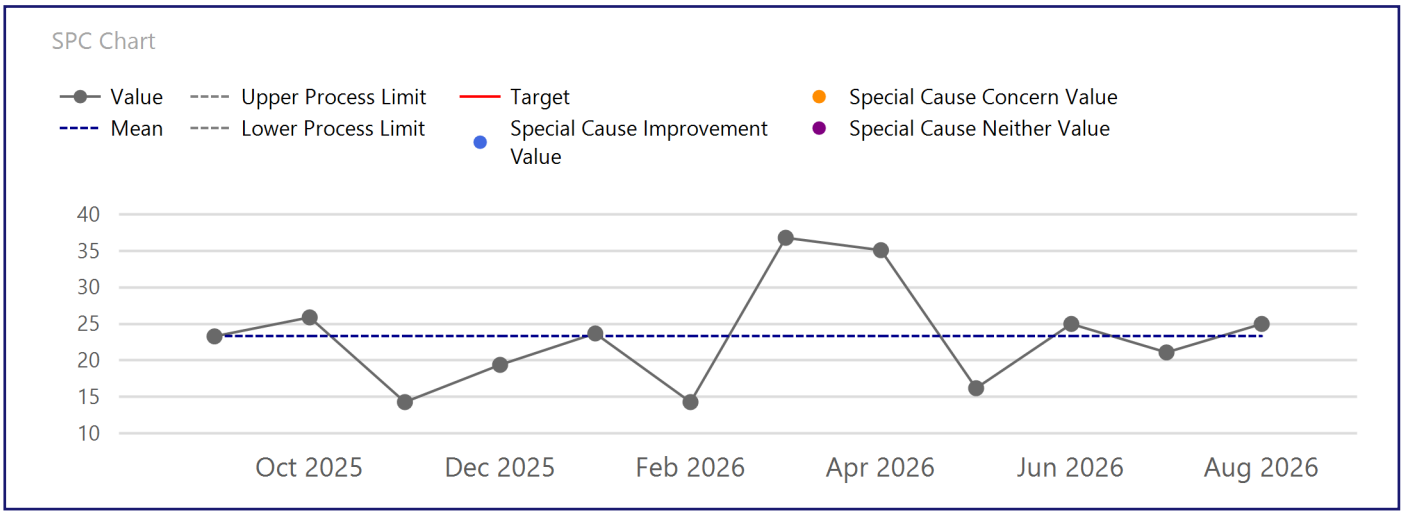
Concerns

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
August 2026	25				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 in Q3

Actions and Owners

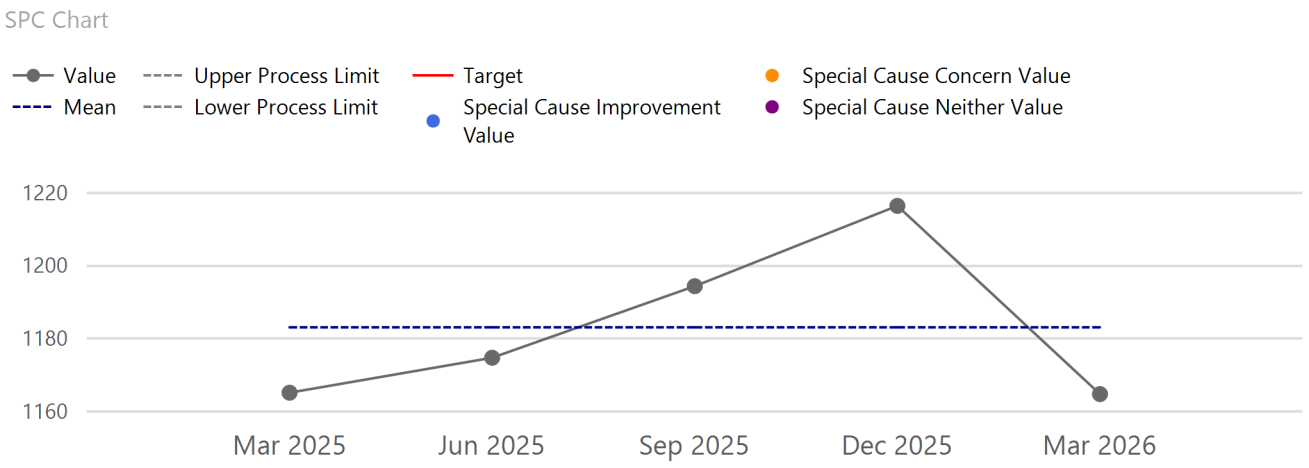
n/a

Concerns

n/a

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

Latest Month	Value	Target	Assurance	Variation	Metric Owner
March 2026	1164.82				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.

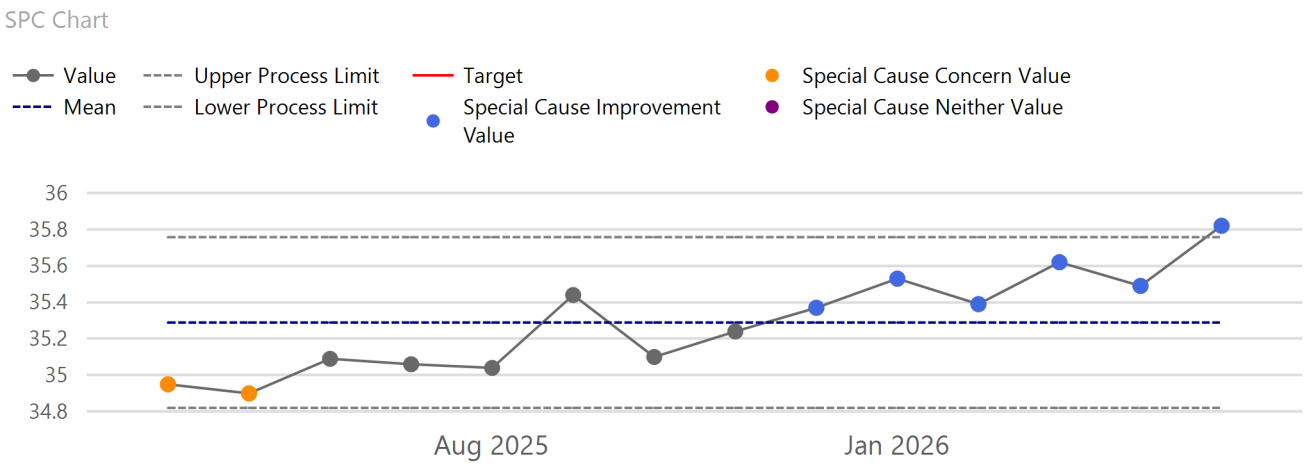
A drive to reduce gabapentinoid prescribing may cause an increase is other analgesia e.g. opioid prescribing, which may also pose safety concerns and be measured in other indicators.

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	35.82			H	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

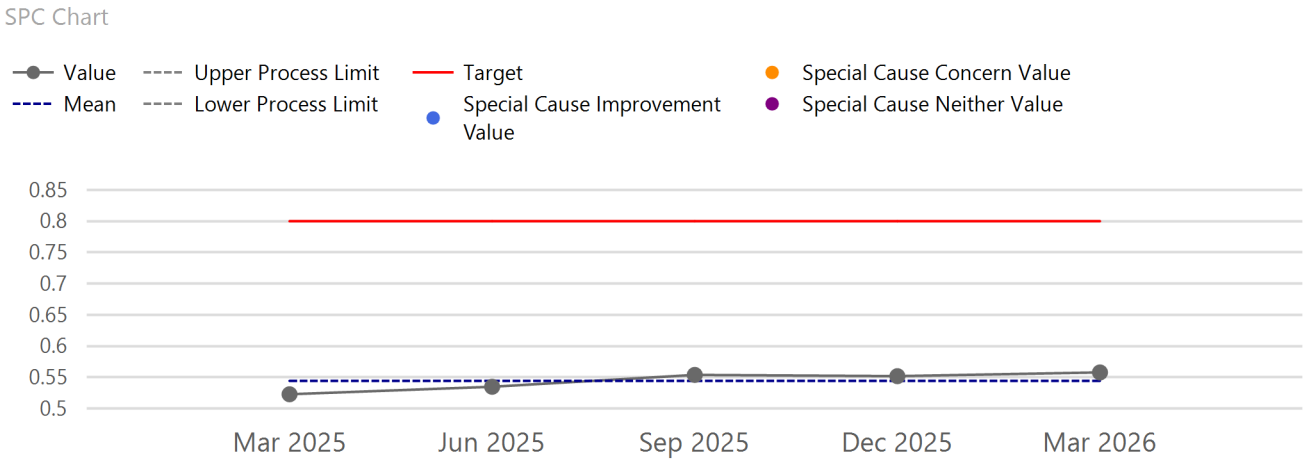
Implementation is limited by patient suitability for extended intervals of prescribing. Some patients and some medications are not suitable for this initiative.

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	0.558	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.

Report Title: *(needs to match agenda)*	Optimising Flow (UEC Workstream 3)		Agenda Item No:		2.3
Meeting:	Finance & Performance Committee	Public	x	Meeting Date:	21.10.2026
		Private			
Lead Executive Title:	Chief Operating Officer				
Report Author/s Title:	Director of Operations for Urgent and Emergency Care				

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)*

Workstream 3 is in controlled implementation across six exemplar wards. Delivery remains variable and the anticipated length-of-stay and bed-day benefits are not yet sufficiently evidenced to count as assured Winter Plan capacity. Weekly ward-level review will track implementation, outcomes and safety, with wider rollout dependent on sustained benefit.

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.

The Committee is asked to:

- take assurance from the controlled implementation and oversight arrangements;
- confirm Clinical Board accountability for delivery, audit and recovery action; and
- note that the Winter Plan capacity contribution remains at risk until improvement is evidenced and sustained.

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

***Where** it's been:*	*UEC programme oversight, Senior Leadership Team*
***When** it went:*	*September 2026*
***What** decision was made:*	*Additional support agreed from shaping change team to help develop plans and scale at pace.*

Main Report

Background & Current Situation

Situation

Cardiff and Vale University Health Board is entering Winter 2026/27 with sustained pressure across urgent and emergency care, acute medicine, inpatient flow, discharge pathways, community services and social care. The Board-submitted Winter Preparedness,

Resilience and Capacity Plan identifies medicine as the principal capacity risk between November and March. Before mitigation, the modelled medical capacity gap ranges from 75.0 beds in November to 110.9 beds in December. Even after the full planned bridge, a residual gap remains. Safe emergency care through winter therefore depends not only on retained and surge capacity, but on reducing demand, avoiding admission and releasing bed days through reliable inpatient flow.

Workstream 3—Optimising Flow—is the principal UEC programme for reducing the bed days consumed by each admission. Six exemplar wards (A2, Lakeside Ward 3, West 5, B6, B1 and B4 North) are testing a common Ward Excellence operating model. The programme has moved from design into controlled implementation; however, delivery remains uneven and a sustained length-of-stay or bed-day benefit has not yet been proven. This is important because the Winter Plan includes a higher-risk planning assumption of 35 beds from ward length-of-stay improvement. That contribution must not be treated as assured capacity until supported by auditable ward-level evidence and sustained safety measures.

Background

Workstream 3 was established to improve hospital efficiency and patient flow through discharge excellence and consistent ward practice. It forms the back-door flow component of the wider UEC Delivery Plan and complements Workstream 1, which reduces avoidable demand through community alternatives, and Workstream 2, which improves front-door decisions, same-day emergency care, frailty pathways and admission avoidance. Together, the three programmes address the winter capacity equation: fewer people reaching hospital, fewer presentations becoming admissions and fewer bed days used for each admission.

The Ward Excellence model is built around five standards: senior review with a clear plan and predicted discharge date; effective multidisciplinary board and ward rounds; daily Red to Green practice with named ownership of delays; early and reliable discharge, including the ambition for 33% of discharges before midday; and ward culture, ownership and continuous improvement. These standards respond directly to the winter objectives of protecting acute capacity, reducing pathways of care delays, increasing seven-day and pre-midday discharge, reducing prolonged stays and avoiding escalation, corridor care, ambulance handover delay and excessive Emergency Unit waits.

The current data demonstrate both opportunity and caution. July 2026 baselines showed wide variation in discharge before midday—28.4% in Medicine, 17.0% in Surgery and 8.3% in Specialist Services—against the 33% ambition. The programme baseline also identified 152 people experiencing pathways of care delay and 7,241 delayed bed days, with targeted reductions of 17% and 15% respectively. Across the six wards, the latest six complete weeks (31 August–11 October 2026) averaged 145.7 discharges per week: 126.8 on weekdays and 18.8 at weekends, with weekends representing 12.9% of discharges. This was 10.2% above the January–March 2026 weekly-equivalent baseline of 132.1, but ward-level variation and short-lived peaks mean that sustained length-of-stay or capacity benefit is not yet proven.

Current actions

- Implementing the Ward Flow Standard Operating Procedure across the six exemplar wards, with consistent board rounds, EDD/PDD recording, daily Red to Green reviews, afternoon wash-up huddles and Friday planning for weekend discharge.
- Developing criteria-led discharge, ready-to-go planning, increased use of the discharge lounge and a Ward Discharge Coordinator test to remove predictable day-of-discharge delays.
- Running weekly exemplar-ward reviews and 30/60/90-day compliance audits, with Clinical Boards expected to own actions, recovery dates and escalation where standards are not met.
- Reviewing long-stay cohorts and the highest-impact POCD cases, including patients staying over 7, 21 and 50 days, to identify internal constraints and partner-dependent delays.

- Building one measurement model that separates process reliability, changes in the discharge profile and proven outcomes. The core measures are board-round and ward-rhythm compliance; discharge before midday and at weekends; discharge on or before PDD; median and average length of stay; avoidable and POCD bed days; and readmission and safety balancing measures.
- Linking ward delivery to the Winter Plan's weekly operational grip, so emerging barriers in workforce, diagnostics, pharmacy, transport, community nursing, social care and Local Authority pathways are escalated through the winter command structure rather than left within individual wards.

Future actions and winter delivery

- Complete implementation across all six wards and require each ward to maintain a visible run chart showing baseline, weekly result, four-week rolling position, cause of variance, action, owner and recovery date.
- Apply a clear benefit rule: recognise improvement only where ward-process reliability increases and discharge timing or length of stay improves against baseline without deterioration in readmission, mortality, incidents or patient safety.
- Quantify released bed days and feed only evidenced, sustained benefit into the controlled winter capacity model. The 35-bed -ward assumption should remain Red until the required evidence threshold is met.
- Protect the daily ward rhythm through named multidisciplinary cover, reliable senior clinical decision-making, sickness and leave contingencies, ward-based coaching and timely pharmacy, therapy, diagnostic and transport support.
- Agree joint response standards with community, primary care, WAST and Local Authority partners, including one shared POCD cohort, named ownership, escalation routes, decision dates and seven-day capacity commitments.
- Use October as the readiness period, November for mobilisation, December to January for enhanced operational control, and February to March for evaluation and decisions to sustain, stop or scale. Wider spread should occur only when the operating model is reliable and benefits are sustained.
- Provide regular updates for board assurance, covering reliability, discharge profile, length of stay, POCD, bed-day contribution, workforce and partner dependencies, safety measures and the effect on the residual winter capacity gap.

Overall assessment. Assurance remains partial. Considerable work is under way within the Health Board and with community, primary care, Local Authority and other system partners to strengthen ward processes, address pathways of care delays and improve discharge. While there are examples of improvement, this collective effort has not yet delivered the consistent and sustained uplift in discharges, reduction in length of stay or release of bed capacity required for winter. The anticipated capacity benefit should therefore not be treated as assured until improvement is evidenced over time and supported by stable safety measures; appropriate escalation capacity must remain available.

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

2.3a - Workstream 3 Finance & Performance Update

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: Yes

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).

Key risks are set out in the main report. These include failure to deliver sustained length-of-stay and bed-day improvement, over-reliance on the unproven 35-bed planning assumption, inconsistent ward-level implementation, workforce and partner dependencies, and consequent pressure on emergency access, escalation capacity and patient flow. Controls include weekly ward review, 30/60/90-day audit, run charts, named actions and recovery dates, safety balancing measures, and retention of appropriate escalation capacity until benefits are evidenced.

Safety: Yes

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).

Reliable senior review, discharge planning and earlier resolution of delays should improve patient safety by reducing avoidable hospital stay, deconditioning, infection risk and harm associated with crowding. There is a potential risk of premature or poorly coordinated discharge if delivery is driven by volume alone. Mitigation is through clinical decision-making, criteria-led discharge, multidisciplinary review, and monitoring of readmission, mortality, incidents, complaints and other safety measures before benefit is recognised or the model is scaled.

Financial: Yes

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).

The programme is intended to release bed days, reduce reliance on escalation capacity and improve use of existing resources. The financial benefit is not yet assured and no cash-releasing saving should be recognised solely from the 35-bed planning assumption. Any additional staffing, ward discharge coordinator, coaching or enabling-service requirements must be identified, costed and approved through existing financial governance. Benefits will be validated against sustained operational and safety evidence before inclusion in capacity or savings plans.

Workforce: Yes

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).

Delivery requires reliable multidisciplinary ward cover, senior clinical decision-making, nursing leadership, pharmacy, therapy, diagnostics, transport and discharge coordination, including at weekends. Existing vacancies, sickness, leave and competing winter pressures may reduce reliability. Mitigation includes named cover and accountability, leave and sickness contingencies, ward-based coaching, weekly escalation of gaps, and assessment of any additional workforce requirement through established workforce and financial processes.

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).

Not applicable. The report describes implementation and oversight of existing clinical and operational practice and does not propose a change requiring specific legal advice. Existing duties relating to safe care, consent, information governance, equality, Welsh language and employment practice continue to apply.

Reputational: Yes

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)

Failure to deliver consistent improvement, or presenting unproven capacity benefits as assured, could reduce confidence among patients, staff, partners, the Committee and Welsh Government. There is also reputational risk from prolonged waits, corridor care, delayed discharge or unsafe

transition. Mitigation is transparent reporting, clear separation of ambition from evidenced benefit, routine safety monitoring, named accountability and timely escalation of delivery constraints.

Socio Economic: Yes - *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.

Consistent discharge planning and reduction of avoidable delay should benefit people whose recovery and ability to return home may be disproportionately affected by deprivation, insecure housing, limited transport, caring responsibilities or reduced access to informal support. Ward and system reviews should identify these barriers early, avoid assumptions about family support, and ensure equitable access to community, transport, pharmacy and social care pathways. Any material service redesign arising from wider rollout should include formal consideration under the Socio-Economic Duty.

Equality & Health: Yes

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)

The operating model should improve outcomes by reducing avoidable delay, deconditioning and harm, particularly for older people, disabled people and those with complex needs. Implementation must ensure reasonable adjustments, accessible communication, involvement of patients and carers, and that discharge decisions are based on individual clinical and social need. A proportionate EHIA should be completed before material changes are made to pathways or before wider rollout beyond the exemplar wards, with differential outcomes monitored where data permit.

Decarbonisation: Yes

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?

The proposals are expected to have a positive impact by reducing avoidable inpatient bed days, duplicated activity and waste, and by supporting care in the most appropriate setting. Potential unintended impacts include additional patient, carer or staff journeys where discharge or follow-up is poorly coordinated. Implementation should maximise coordinated discharge, remote communication where clinically appropriate, efficient use of transport and medicines, and avoidance of unnecessary repeat visits. No adverse decarbonisation impact is currently anticipated.

Welsh Language: Yes

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?

The programme must support patients to communicate and receive information in Welsh without disadvantage, in line with the Welsh Language Standards and *More than just words*. Patient-facing discharge information, signage and key materials should be available bilingually; language preference should be identified and recorded; and interpreting or Welsh-speaking support arranged where required. No adverse impact is intended, but compliance should be checked as the model is standardised and scaled.

Workstream 3: from ward practice to measurable capacity

Six exemplar wards are the controlled test for a standard operating model that can be scaled safely across the organisation.

EXECUTIVE MESSAGE

The programme has moved from design into implementation. The six wards now provide a common test of ward rhythm, earlier discharge and seven-day flow. Outcome attribution must now be demonstrated ward by ward.

Reliable ward rhythm

Board rounds
EDD/PDD
Red to Green
PM huddles

Earlier discharge

Ready-to-go planning
33% pre-midday aim
Discharge lounge use

Seven-day progression

Friday weekend plan
Criteria-led discharge
Diagnostics and therapy

Reduced avoidable days

Lower LOS tail
Fewer >7 / >21 / >50 days
Reduced POCD bed days

Committee focus

Is implementation reliable, is the discharge profile changing, and when can a sustained bed-day benefit be safely recognised?

The six excellence wards are the exemplar test bed

A2, Lakeside Ward 3, West 5, B6, B1 and B4 North test one common operating model while addressing local barriers.

- A2 (Medicine)
- Lakeside Ward 3 (Medicine)
- West 5 (Trauma)
- B6 (Surgery)
- B1 (Cardiology)
- B4 North (Neuro)

What "success" means now

1. Same standards used daily
2. Barriers identified and escalated
3. Earlier and weekend discharge improves
4. LOS shifts without safety deterioration

FOUNDATION
Ward Flow SOP and standards issued

IMPLEMENT
Board rounds, EDD/PDD and Red to Green

EMBED
PM huddles, Friday planning and CLD

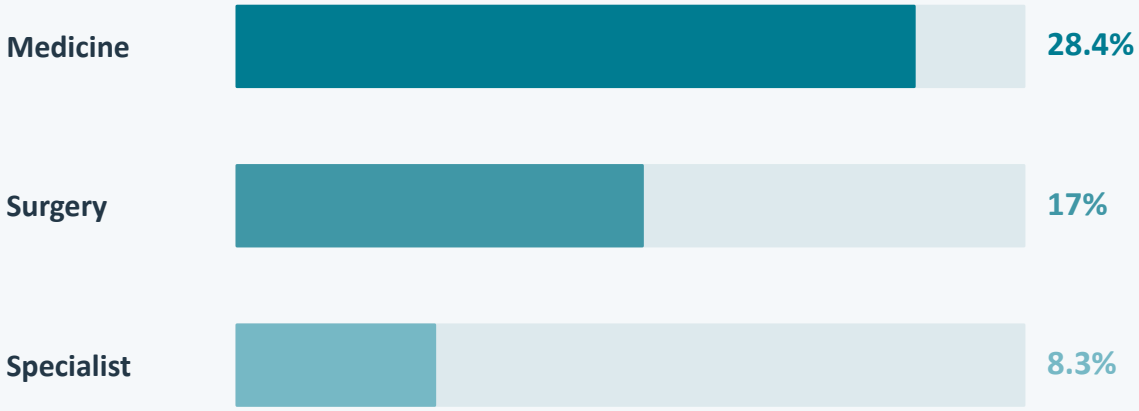
PROVE
Ward run charts and sustained LOS benefit

Current assurance: operating foundations are in place, but implementation remains uneven and LOS attribution is not yet proven.

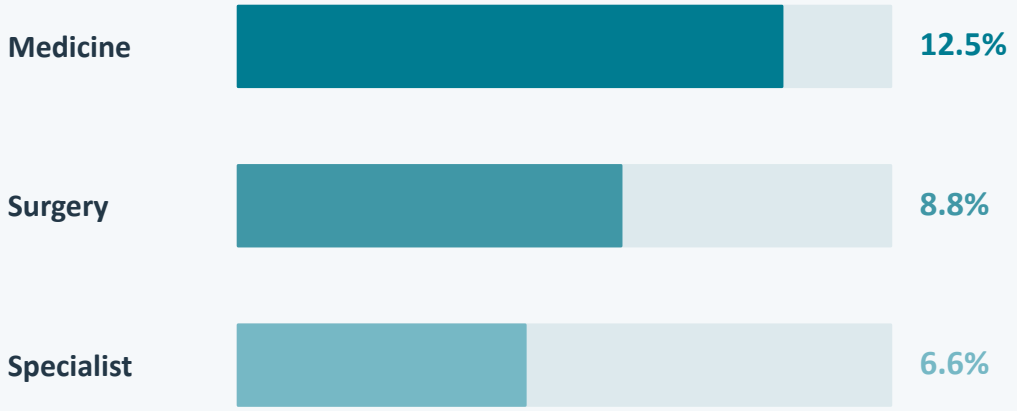
The opportunity is visible in the discharge profile

July 2026 baselines show material variation between Clinical Boards and a clear gap to the common ambition.

Discharges before midday



Weekend discharge baseline



33% target by November 2026

+5% improvement by March 2027

POCD people

152 baseline
17% reduction

POCD bed days

7,241 baseline
15% reduction

Average LOS*

12.12 | 10.45 | 7.20
Reduction by Nov 2026

*MCB | Specialist | Surgery, excluding zero-day stays

Six wards delivered 86 more discharges than average

June–August averaged 150.5 discharges a week versus 144.4; weekday flow drove 93% of the uplift.

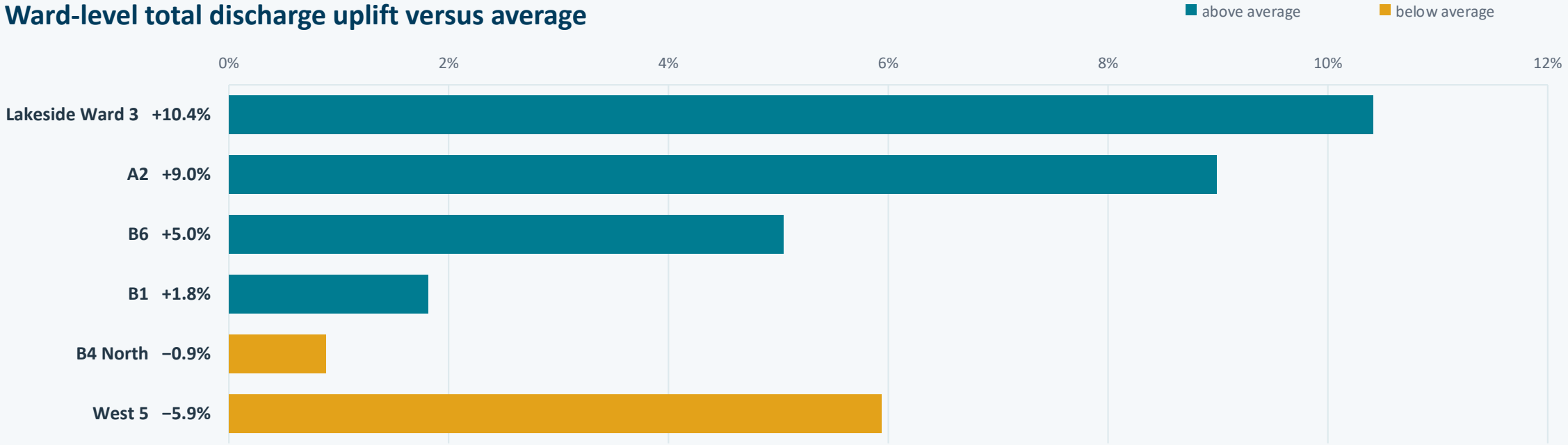
+4.2%
six-ward weekly uplift

+4.5%
weekdays • +80 discharges

+2.2%
weekends • +6 above avg

4 of 6
wards above average

Ward-level total discharge uplift versus average



Source: Cardiff & Vale UHB – Weekday vs Weekend Discharges. Average = 65-week mean (9 Jun 2025–31 Aug 2026); recent period = 14 weeks (1 Jun–31 Aug 2026).

The measurement model connects practice, output and outcome

A Finance and Performance view should distinguish delivery progress from proven benefit and use one weekly ward-level scorecard.

PROCESS RELIABILITY	DISCHARGE PROFILE	LOS / CAPACITY OUTCOME
Board-round compliance EDD/PDD recorded Red to Green daily PM huddle Friday weekend plan	% before midday Weekend discharge rate Daily discharge curve Criteria-led discharge On or before PDD	Median and average LOS Observed vs expected >7 / >21 / >50 days Avoidable / POCD bed days Readmission and safety

Decision rule **Recognise improvement only when process reliability rises and discharge timing or LOS improves against baseline, without deterioration in readmission or safety.**

Immediate control for the six wards **Baseline | weekly result | four-week rolling position | cause | action | owner | recovery date**

Next phase: prove, scale and convert benefit into winter resilience

The six-ward test must now produce auditable evidence, owned by Clinical Boards, before wider spread or capacity assumptions are made.

SEP–OCT

Implement

SOP, standards and local leadership
30/60/90-day compliance audit

OCT–NOV

Test

Kaizen/PDSA tests
33% pre-midday trajectory

DEC–FEB

Evaluate

Ward-level outcome and safety review
Sustained benefits test

FROM FEB

Scale

Spread only what is reliable
Link to capacity decisions

Committee assurance requested

1. Endorse the six wards as the controlled exemplar and require ward-level run charts.
2. Require Clinical Boards to own delivery, corrective action, trajectory and evidence of benefit.
3. Receive a monthly Workstream 3 view covering reliability, discharge profile, LOS, POCD and safety.

Delivery is fragile unless critical enablers are secured

Correspondence points to a common need: practical capacity and authority to make the ward standard work every day.

FOUR MATERIAL DELIVERY RISKS

01 Sickness and workforce capacity

Sickness can remove key roles and break MDT attendance, action ownership and PM huddles; capacity already limits engagement.

Control: Protect named cover and MDT time; track absence alongside reliability.

02 POCD and partner pathways

Social assessment, district-nursing vacancies and care capacity can delay patients despite better ward practice.

Control: Use one joint cohort list, owner, escalation route and decision date.

03 Digital and data infrastructure

Inconsistent PDD/R2G data, incomplete dashboards and manual reporting obscure causes and benefits.

Control: Complete one validated ward view, metric dictionary and reporting.

04 Adoption and discharge enablers

PM huddles and CLD remain uneven; training and seven-day support gaps threaten sustained spread.

Control: Provide ward coaching, 30/60/90-day audit and named recovery.

THE THREE MAIN ASKS

Protect practical delivery capacity

Named ward leads, reliable senior MDT attendance, sickness cover and ward-based coaching.

1 Protect the daily rhythm

Secure named multidisciplinary cover and time to complete board rounds, actions and PM huddles.

2 Resolve partner dependencies

Agree response standards, capacity commitments and rapid escalation for POCD pathways.

3 Make performance visible

Fund one trusted digital ward view linking reliability, discharge, LOS, POCD and safety.

Evidence: September assurance; August ward programme and recovery briefing; correspondence and meetings reviewed June–September 2026.

Report Title:	2026-27 Annual Plan: Quarter Two Report		**Agenda Item No:**		2.4
Meeting:	Finance & Performance Committee	**Public**	X	**Meeting Date:**	21.10.2026
		Private			
Lead Executive Title:	Executive Director of Strategy Planning and Partnerships				
Report Author/s Title:	Strategic Planning & Delivery Manager and Senior Strategic Planning Manager				

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.

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)*

Our delivery confidence of the annual plan has reduced in quarter 2, due to a reduction in the number actions assessed as Green, an increase in Amber ratings and the emergence of Red-rated actions (see Slide 9). Whilst delivery activity remains underway across the majority of priorities, a greater proportion of actions are experiencing risks, dependencies and delivery challenges that require active management and oversight.

The Quarter 2 position reflects the challenges associated with moving from programme mobilisation into implementation. As programmes mature, a more comprehensive understanding has emerged of the complexity associated with delivering both strategic transformation and operational improvement within the current organisational context. A number of recurring themes are affecting delivery across the portfolio, including organisational and programme capacity constraints, competing operational pressures, programme maturity and governance challenges, and dependencies on wider organisational, regional and national decisions (see Slide 10). These factors are impacting delivery pace, increasing implementation risk and reducing confidence in the achievement of planned milestones.

Crucially this means that we are not seeing the progress we would like against key outcome measures, as shown in slide 8.

To ensure that we make progress on the health board's top priorities, we are working with NHSP&I to improve our integrated improvement plan for the remainder of the year, to have an updated version in place for the end of October. This will put a specific focus on reducing 2-year waits, bringing down inpatient length of stay (LoS), laying the foundations for community by design, driving the implementation of the quality management system, improving our culture, and preparing for the organisation redesign.

While progress continues across all of our strategic and operational priorities, and delivery activity remains underway across the majority of Annual Plan actions, the Quarter 2 position highlights the need for clear focus on our top priorities, and recovery of actions under greatest pressure.

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

Board/Committee Response Required *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 are requested to: **NOTE** the progress highlighted in the Q2 Annual Plan Report **APPROVE** submission of the Q2 position to Welsh Government

Governance Route *(please list all other Committee/Groups this report has been to)*	
Where it's been:	No previous governance route
When it went:	N/A
What decision was made:	*N/A*

Main Report *Background & Current Situation*
This report provides an overview of Quarter 2 progress against delivery of the actions set out in the Health Board's 2026/27 Annual Plan. Monitoring delivery of the Annual Plan is an essential component of effective strategic planning, supporting organisational agility, informed decision-making and robust governance. For 2026/27, a revised reporting format has been introduced, providing a dashboard-based overview of productivity and efficiency measures, overall Annual Plan delivery, progress against strategic priority actions and key operational priorities. This approach enables clearer oversight of performance, delivery risks, and next steps, while highlighting actions that contribute directly to targeted intervention and de-escalation objectives. The full report is shown in the appendix.

Appendices: *(List any appendices that will accompany this report).*
• Annual Plan 2026-27 Quarter 2 Report

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
Risk: No
N/A
Safety: No
N/A
Financial: No
N/A
Workforce: No
N/A
Legal: No
N/A
Reputational: No
N/A
Socio Economic: No
N/A
Equality & Health: No
N/A
Decarbonisation: No
N/A
Welsh Language: No
N/A

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

October 2026

Annual Plan 2026-27

Quarter 2 Report

Cardiff and Vale University Health Board



Purpose and scope

- The purpose of this dashboard is:
  1. To provide a clear, consistent view of in-year progress against the 2026/27 Annual Plan
  2. To focus attention on delivery of near-term commitments, alongside progress on longer-term strategic transformation
  3. To enable informed oversight, challenge and support through a proportionate RAG assessment

- <u>Scope and Focus of Reporting</u>

  The 2026/27 Annual Plan sets out a broad range of commitments, including minimum delivery expectations, enabling actions, Ministerial Advisory Group (MAG), and Improving Performance Together (IPT). This dashboard focuses specifically on reporting progress against the qualitative strategic priorities of the plan, in line with the approach taken in previous quarterly reporting cycles. Other elements of the Annual Plan - primarily those relating to quantitative performance measures - are monitored and reported through alternative mechanisms, such as the Integrated Performance Report.

How to read this dashboard

- The dashboard is structured as follows:
  - Productivity & Efficiency: Key measures presented up front as outlined in the 2026/27 Annual Plan, linked to related strategic and operational activity
  - Overall Annual Plan Delivery: Overview of delivery across all 46 annual plan actions.
  - Strategic priority actions: Two slides per portfolio assessed against each Portfolio's Strategic Intent detailing RAG, progress, risks and next steps
  - Key operational priorities: Performance against priority operational actions detailing RAG, progress, risks and next steps
  - Targeted Intervention: Assessment of progress against the quantitative Targeted Intervention Criteria measures, including performance trends, RAG status, key recovery actions and next steps.

Productivity & Efficiency Monitoring

This section of the report places a strengthened focus on **productivity and efficiency**, reflecting the Health Board's commitment within the **Annual Plan 2026/27** to deliver sustainable improvements in performance and value.

The following framework, originally set out in the Annual Plan, identifies our **high-value opportunities** across key service areas. It brings together a defined set of **outcome measures** spanning flow, workforce, theatres, outpatient care and population health.

We are using this framework to **monitor progress throughout the year**, tracking q**uarterly progress (Q1–Q4)** to assess delivery against the plan.

This approach supports a shift from reporting on delivery alone to **understanding whether actions are improving system performance**. It provides a **consistent line of sight from Annual Plan priorities to measurable outcomes**, enabling early identification of where progress is on track and where further intervention is required.

Productivity & Efficiency Monitoring

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

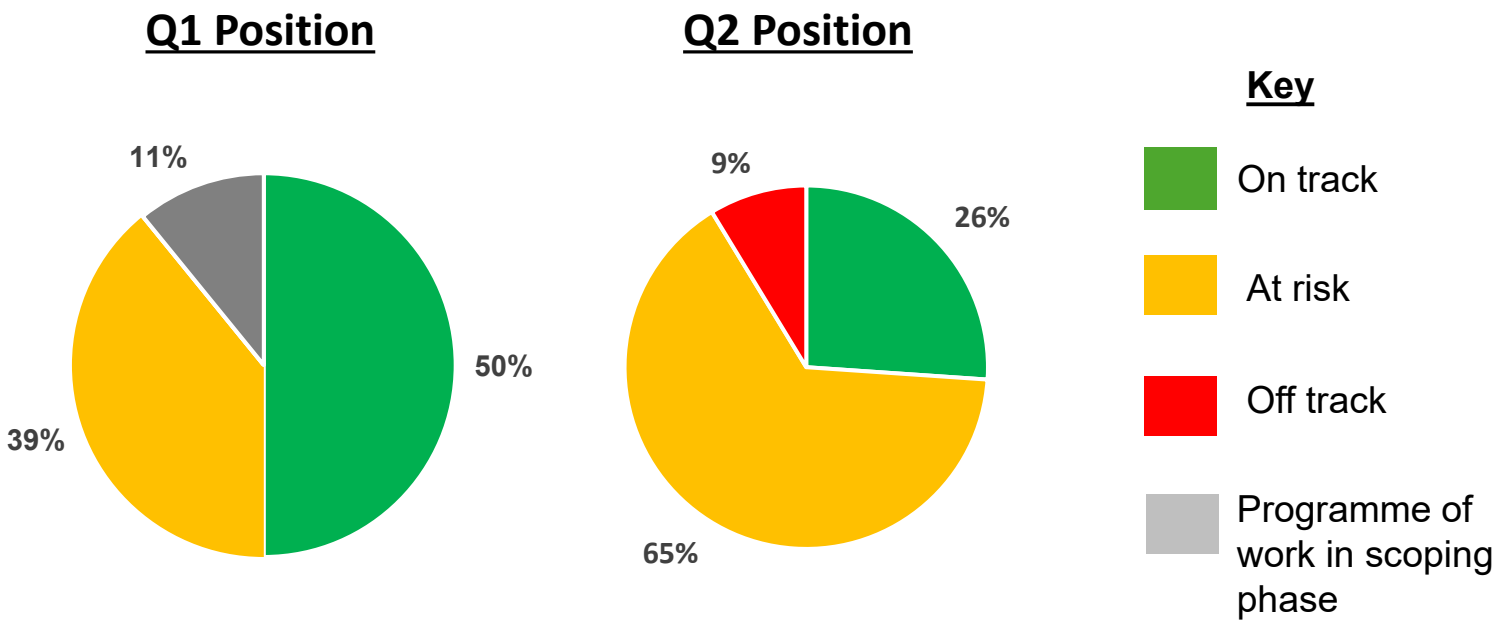
High Value Opportunity	Scope	Baseline Position 2025-26	Target Position by Q4 2025-26	Opening position 2026-27	Target Position by Q4 2026-27	Q1 2026-27	Q2 2026-27
Optimising time spent in hospital	• Reducing non-elective medicine LoS to peer mean (medicine)	13.7 days	11.9 days	14.6 days	13.6 days	12.12 days (July) (Note this is for Medicine, excluding 0-day stays)	13 days (Sept) (Note this is for Medicine, excluding 0-day stays)
	• Pathway of Care delays Bed days per month	10069	-	7452	6900	7,977 (June)	7,370 (Sept)
Theatres productivity	• Improving "in" theatre session utilisation to GIRFT standard:	79%	85%	75%	85%	78% (April)	77% (Sept)
	• Improving "of" theatre utilisation	80%	90%	83%	90%	82% (April)	87% (Sept)
Outpatients efficiency	• Reducing DNA rates	11%	5%	8.60%	5%	8.5% (June)	8.4% (Sept)
	• Follow Ups - see on symptoms / patient initiated follow up for nationally mandated pathways	3.4% / 0.8%	20%	4.3% / 1.6%	8% / 4%	4.2%/ 1.4% (June)	4.2%/ 1.3% (Sept)
Mental Health	• OOA placements	-	-	23	5	24 (End of June position)	20 (End of Sept position)
Workforce - including improving wellbeing and availability to work	• Improved Attraction and Retention- Turnover	9.40%	< 9%	8.04%	< 9%	7.85%	7.45%
	• Increased engagement score	72%	74%	69.20%	74%	*Engagement update due in Q4 (annual survey)*	
	• % headcount personal appraisal and development review in past 12 months	79%	85%	72.75%	85%	76.22%	75.44%
	• Improved medical job planning	43%	> 90%	82.45%	>90%	80.82%	77.60%
	• Agency usage (30% reduction)	£8.7m	£5.5m	£5.5m	£3.8m	£1.3m	£2.7m
	• Improved sickness absence rates / availability of staff	6.25%	<5.5%	6.42%	5.50%	6.39%	6.36%
Commissioning	• Clinical Coding % compliance	70.0%	85.0%	75%	80%	87.1% (June)	*Not yet available*
Public Health – Protecting and improving the health of the local population	• Percentage uptake of the influenza vaccination amongst adults aged 65 years and over	66.9%	72.0%	73.0% (9 Mar 2026)	73.0%	*N/A – vaccination programme not running in Q1 & Q2*	
	• Percentage uptake of influenza vaccination amongst staff	36.0%	56.0%	64.2% (5 Mar 2026)	65%		
	• Maintain levels of healthy weight children	77.5% (2022-23)	77.5%	77.7% (2023-24)	77.8%	*75.3% (2024/25 latest available)*	
	• Reduce smoking rates	13.0% (2023-24)	12.90%	9.0% (2024/25)	8.9%	*9.0% (2024/25 latest available)*	

Overall Annual Plan Delivery

This slide provides an overview of the current RAG status of all 46 annual plan actions, highlighting overall delivery performance.

*Note - RAG ratings reflect delivery of agreed actions and planned milestones, not the underlying performance outcomes. This approach recognises that the Annual Plan focuses on delivering the key enablers required to improve performance over time.

Delivery RAG Status of Annual Plan Actions



- All Annual Plan actions have now progressed beyond the initial scoping phase and are subject to formal delivery monitoring.
- The number of Green actions has reduced, with a corresponding increase in Amber ratings, reflecting increasing delivery pressures and a more mature understanding of programme risks, dependencies and implementation challenges.
- Amber indicates that delivery remains achievable but requires active management and oversight to address identified risks and dependencies.
- A small number of actions are assessed as Red, indicating areas where delivery is under significant pressure and requiring recovery action, revised delivery approaches or resolution of key dependencies. Further detail is provided in the following sections of the report

Key Challenges and Ongoing Areas of Improvement

Whilst delivery activity continues across the Annual Plan, Quarter 2 highlights a number of recurring challenges that are affecting the pace of implementation and confidence in the achievement of planned milestones. These challenges are evident across a number of strategic and operational actions and, in many cases, are affecting delivery confidence rather than preventing progress altogether.

- **Organisational capacity and competing priorities -** Delivery of a number of programmes is being affected by workforce, clinical and programme capacity constraints. These challenges are compounded by the requirement to progress transformation activity whilst responding to significant operational pressures and service demands, impacting the pace at which some programmes can be progressed.

- **Programme governance, delivery planning and implementation readiness -** As programmes move from planning and mobilisation into implementation, a number of actions continue to refine delivery plans, governance arrangements, reporting mechanisms, milestones and accountability arrangements. This can reduce confidence in delivery trajectories and make consistent monitoring of progress more challenging.

- **Dependencies and complexity of delivery -** Several actions remain dependent on wider organisational decisions, regional programmes, partner organisations, funding approvals and enabling workstreams. These dependencies can influence both the pace and sequencing of implementation activity and, in some cases, sit outside the direct control of individual programme,

Strengthening the link between action delivery and outcomes

The Quarter 2 monitoring position continues to highlight variability in the maturity of outcome measures, benefits realisation arrangements and performance monitoring across the portfolio. Whilst progress is being reported against the completion of planned actions and milestones, it is not always possible to consistently demonstrate the impact of delivery activity through agreed outcome measures and indicators. This remains an important area of organisational learning and has informed development of the revised approach to Annual Planning for 2027/28, which places greater emphasis on the alignment between planned actions, measurable outcomes, benefits realisation and performance monitoring arrangements.

Strategic Priority Actions

This section provides an overview of progress against the **Annual Plan 2026/27 key priority actions** linked to the CAV UHB **Strategic Portfolios.**

- 28 priority actions are driven through the Portfolio structure, each assigned a unique Action ID to support tracking and reporting
- Every action has a named **SRO** and **Delivery/Reporting Lead**, with a **Plan-on-a-Page** developed to support delivery

Two slides are presented for each Portfolio.

The slides:
1. Restates the Portfolio's **strategic intent** and **success indicators** to maintain line of sight to agreed priorities
2. Reports **progress against the key actions** within that Portfolio, supported by a **RAG assessment** (including trend).

This approach supports **consistent oversight of delivery** and highlights where further focus or intervention may be required.

Summary of Portfolio Action Status

Update – Q1 2026

Clinical Services

Key progress

- CSP plans on a page completed, informing annual planning and initial programme priorities.
- Community by Design governance and workstreams established, with initial delivery underway.
- Regional, cancer and specialised services planning progressing, with key Q3 actions identified.

Quality

Key progress

- Baseline assessments and Maturity Matrices have been completed across all Clinical Boards and corporate functions
- Building Capability work commenced and Quality Excellence projects continue to progress.
- Infection Prevention Surveillance project is being re-scoped.

Population Health

Key progress

- Vaccine Equity Plan consultation complete, with final draft planned by end of October.
- Good Food and Movement Implementation Plan progressing with local authority partners.
- Smoking cessation offer expanded, with 134 smokers supported across Q1 and Q2.

People & Culture

Key progress

- People & Culture Plan refresh underway, with draft due to Committee in November.
- Leadership capability assessment complete, with priority management development actions underway.
- Workforce planning, demand and capacity, and integrated workforce planning work progressing.

Future Generations

Key progress

- SOFG Annual Report drafted for November Portfolio Board consideration.
- Clinical Sustainability Leads identified across all Clinical Boards.
- Working group established to produce a Clinical Sustainability and Decarbonisation Plan.

Infrastructure - Digital

Key progress

- Digital Foundations funding remains outstanding; an alternative prioritised plan is in development.
- Connecting Care funding confirmed for 2026/27, with recruitment underway.
- LIMS2 November go-live is at risk; WECDS delivery remains capacity constrained.

Infrastructure - Estates

Key progress

- Acute estate demolition plans continue to progress.
- Priority UHW infrastructure risks identified
- Redevelopment vision group and designer in place.
- Multi-agency community estate planning progressing, with the Community Infrastructure Plan refresh planned.

Priority actions – Clinical Services

Clinical Services

Deliver a sustainable, future-ready clinical model by moving the Clinical Services Plan into coordinated delivery and service-level planning, enabling integrated, system-wide redesign and improved outcomes for the population.

ID	Priority Area	RAG Status*	Evidence of Progress – Achievements, Risks, Next Steps
1	Clinical Services Plan Delivery		CSP plans on a page have been completed and informed annual planning. Initial programmes, including Mental Health Transformation, have been identified for Portfolio Board consideration in Q3. A draft service-level planning approach has also been developed for approval, although capacity risks remain around testing and delivery.
2	Community By Design Programme		Programme documentation, governance and workstreams plans are in place, with leads identified and initial actions underway. Strategic support procurement process near completion. Governance has been aligned with the existing UEC Programme Board to reduce duplication.
3	South East Wales Regional Planning		The regional orthopaedic plan and LHP business case have been submitted to Welsh Government, and the Endoscopy Programme has been refreshed. A Regional Planned Care Board and clinical service planning group are being established, with work also underway on a shared demand and capacity approach. CoCreate has been appointed to strengthen regional collaboration and leadership.
4	Velindre Partnership		The Complex Oncology Joint Provider Plan and delivery roadmap were endorsed in July. Low-acuity haematology project remains Amber due to data-related delays, although baseline assessments were completed in Q2 and service specification work will progress in Q3. An October partnership stocktake will inform 2027/28 priorities and the phased delivery plan.
5	Specialised Services		Clinical Boards are reviewing specialised services risk assessments, with moderation and prioritisation planned for October to inform the JCC Provider Risk submission and 2027/28 annual plan priorities.

**RAG based on progress against agreed deliverables, not outcome performance.*

Priority actions – Quality

Quality

Create a health board-wide system and culture for quality in its broadest sense, using Shaping our Future Quality Excellence to eradicate avoidable harm and integrate quality, safety, governance and value.

ID	Priority Area	RAG Status*	Evidence of Progress – Achievements, Risks, Next Steps
6	QMS Development		The QMS position statement and Implementation Plan were approved and submitted to NHS P&I during 25/26 Q4 and Q1 26/27 as per requirement. Baseline assessments and Maturity Matrices have been completed during Q1 and Q2 across all Clinical Boards and corporate functions, with the prototype progressing as planned with presentation at national meeting during Q2
7	Quality Excellence Programme		The Building Capability work has commenced, informed by learning from the Maturity Matrices, and will continue in Q3. Other projects are progressing as planned, Infection Prevention Surveillance is being re-scoped due to delays in digital resourcing issues. Scan for Safety has also been added to the programme.
8	Patient Safety Framework		Roll out of the risk register for clinical risks is now complete. Work continues to refresh the patient safety, quality and experience framework. Clinical governance framework has been approved and is being implemented across the organisation for floor to board reporting.
9	Availability of Quality Data		Work is progressing to strengthen clinical audit and benchmarking arrangements, including Mortality Dashboard and wider clinical audit participation. Development of the CHKS users guide and quality indicators has not yet started.
10	Value-based approaches		Programme Manager returns to work in Q4. Work will not be completed this year and will need to be prioritised moving forwards.

**RAG based on progress against agreed deliverables, not outcome performance.*

Priority actions – Population Health

Population Health

Improve lives and reduce unfair differences in health outcomes through targeted, whole-system prevention and population health interventions.

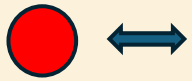
ID	Priority Area	RAG Status*	Evidence of Progress – Achievements, Risks, Next Steps
11	Vaccination		Consultation on the Vaccine Equity Strategic Plan refresh is complete with insight gathered from health professionals, public and voluntary sector partners and community representatives. A draft plan is in development but some further work is required, particularly in the data section, to finalise. A work plan has been discussed to ensure the final draft is available by the end of October 2026.
12	Healthy Weight		Implementation Plan (2026-2028) went to Vale Business Cabinet in September for deep-dive discussion. Good Food and Movement approach agreed with new Leader of Cardiff Council.
13	Tobacco Control		134 smokers were supported through the Allen Carr Easyway programme during Q1 and Q2. Help Me Quit provision has been strengthened in hospital settings, including support at UHL and a new UHW Pre-Operative Assessment clinic, alongside a new initiative for people with learning disabilities.
14	Diabetes		Strategic Diabetes Action plan developed building on key evidence base and national guidance– Health Needs Assessments, updated Diabetes Quality Statement. Slight delay in adoption pending further refinements.
15	Women's Health		Strategic plan developed incorporating Women's Health Plan for Wales requirements, key delivery expectations for 26/27, and key recommendations from the Women's Health Needs Assessment. Funding from Welsh Government yet to be confirmed.

**RAG based on progress against agreed deliverables, not outcome performance.*

Priority actions – People & Culture

People & Culture

Strengthen, stabilise and support the workforce through a refreshed People and Culture plan, creating conditions for a healthy, engaged, inclusive and sustainably staffed organisation that enables the future model of care.

ID	Priority Area	RAG Status*	Evidence of Progress – Achievements, Risks, Next Steps
16	P&C Plan		Engagement on the People & Culture Plan refresh commenced in August. Timescales have been adjusted to allow further engagement and Committee review of the draft plan, which will be considered in November before progressing to Board in January 2027.
17	Workforce Organisational Redesign		A Change Director will be appointed to lead the organisational redesign. Further work is required to establish the foundations for change, agree the future structure and ensure clear organisation-wide communication on the purpose of the redesign and its relationship to the CSP.
18	Leadership		The Leadership & Management Capability Assessment is complete and delivery of priority actions has commenced, including the Line Manager Responsibility Framework and Manager Passport. CEWS has progressed into a broader Organisational Health model, with dashboard, heatmap, pulse survey and support framework developed ahead of pilot implementation to support earlier identification of workforce pressures.
19	Workforce Planning		Work continues to strengthen workforce planning and data, including reconciling ESR establishments with the general ledger and developing a new Amendment App. The Demand and Capacity Programme has commenced and work is underway to develop an integrated activity, workforce and finance plan for 2027/28. Nursing workforce supply and demand planning is also progressing with HEIW.
20	Staff Health & Wellbeing		MAAW training has been redesigned and expanded, and workforce data increasingly used to target absence and wellbeing interventions. The employee wellbeing service review has identified the need for a more integrated model across wellbeing, psychological support and occupational health, with the future service model and access improvements now being progressed together.

**RAG based on progress against agreed deliverables, not outcome performance.*

Priority actions – Future Generations

Future Generations

Embed a coherent, forward-looking approach to sustainability and innovation by establishing the Shaping Our Future Generations Portfolio and delivering coordinated decarbonisation, research and innovation.

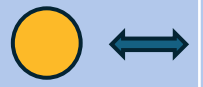
ID	Priority Area	RAG Status*	Evidence of Progress – Achievements, Risks, Next Steps
21	Future Generations Portfolio Development		SOFG Annual Report draft to be shared at November Portfolio Board with agreement of reporting schedule and assurance mechanisms.
22	Decarbonisation		Clinical Sustainability Leads have been identified across all Clinical Boards, and the working group has been successfully established. The group is actively progressing and delivering the actions outlined in the work plan to produce Clinical Sustainability and Decarbonisation Plan.

**RAG based on progress against agreed deliverables, not outcome performance.*

Priority actions – Infrastructure (1)

Infrastructure - Digital

Deliver user-centred, interoperable digital systems, real-time data insights and resilient infrastructure that improve patient and staff experience, reduce harm and enable delivery of the Clinical Services Plan.

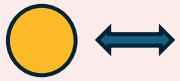
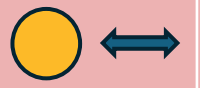
ID	Priority Area	RAG Status*	**Evidence of Progress –** Achievements, Risks, Next Steps
23	Digital Strategy & Operating Model		Welsh Government confirmation of Digital Foundations funding remains outstanding. In parallel, an alternative plan is being developed of actions that could be progressed subject to available discretionary capital. This is currently in draft with Director of Digital Health Intelligence for review and comment.
24	National Digital Programmes		Delivery of national digital programmes is progressing, with Connecting Care funding confirmed for 2026/27 and recruitments underway to implement the PARIS Connecting Care programme. However, implementation issues are putting the planned LIMS2 November go-live at risk, while delivery of the WECDS EU Dataset remains constrained by capacity and competing clinical and digital priorities.
25	Digital Enablers		Progress remains dependent on the outcome of the Digital Foundations funding request. An alternative plan is being developed to prioritise achievable improvements to digital enablers, recognising that progress may be incremental without the requested capital investment.

**RAG based on progress against agreed deliverables, not outcome performance.*

Priority actions – Infrastructure (2)

Infrastructure - Estates

Optimise and future-proof the Health Board estate across acute and community settings by maximising utilisation, addressing critical infrastructure risk, and working with partners to deliver sustainable estates aligned to the Clinical Services Plan.

ID	Priority Area	RAG Status*	Evidence of Progress – Achievements, Risks, Next StepsProgress Update
26	Utilisation of Acute Estate		Demolition of Brecknock House and the Sports & Social Club is now due for completion by the end of October. A review of alternative accommodation for Glamorgan House and Monmouth House is also underway. Tendering for demolition of Carmarthen and Denbigh Houses is also progressing in October.
27	Acute Estate Modernisation		The urgent estates and infrastructure plan is progressing, with the top 10% estate risks identified for UHW. A group has been established, and a designer appointed to develop the UHW redevelopment vision. Suitable accommodation is being explored for ALAS relocation.
28	Multi-agency Community Estate		Multi-agency estate schemes continue to progress, with good engagement from all partners. A joint workshop is planned for November to strengthen partnership processes and longer-term planning. As the Community by Design Programme develops, strategic aims, deliverables, measures and governance will be reviewed to ensure they remain realistic, impactful and population-focused. Following completion of community estates baseline work, the Community Infrastructure Plan will be refreshed .

**RAG based on progress against agreed deliverables, not outcome performance.*

Key Operational Actions

This section provides an overview of progress against the Annual Plan 2026/27 key priority actions that are not aligned to the Strategic Portfolio structure.

A total of **18 priority actions** are included within this category. These actions are primarily managed through Clinical Boards and span a range of cross-cutting themes, including organisational redesign, length of stay, medicines management, primary & community care, urgent & emergency care, planned care & cancer, diagnostics & therapies, women & children's services, and mental health.

Many of these actions have clear links to the productivity and efficiency measures shown at the beginning of the report.

*NOTE - 3 of the 18 actions are captured as part of a broader strategic portfolio action so not updated in the following slides. These are action ID 36, 43, 44.

Operational Actions

ID	Priority Area	RAG Status*	**Evidence of Progress –** Achievements, Risks, Next Steps
29	Operational Redesign		A Change Director will be appointed to lead the organisational redesign. Further work is required to establish the foundations for change, agree the future structure and ensure clear organisation-wide communication on the purpose of the redesign and its relationship to the CSP.
30	Length of Stay Reduction		Length of stay improvement continues through the UEC Improvement Programme, with strengthened performance review and escalation arrangements in place. Ward efficiency work is being embedded across six pilot wards, with additional Shaping Change support and a planned Kaizen Blitz to accelerate improvement and inform future scale-up.
31	Medicines Management Improvements		An initial review of NICE medicines spend has been completed and is being expanded to include CAV non-NICE spend, out-of-area spend and NWJCC commissioned medicines. Findings will be presented to Management Executive to agree next steps, with significant clinical engagement required before any changes can be implemented.
32	End of Life Care Transformation		Delivery continues to progress well, with Supportive Care Expansion 95% complete and Front Door 90% complete. ALISE and Tidal Zone 2 are both 60% complete, with Year 2 milestones set out. Benefits are being monitored against bed days saved and reduced length of stay.
33.	Enhanced Community Care Expansion		Service redesign continues through Community by Design. Work continues on workforce capacity, remodelling MDT arrangements and alignment with Integrated Neighbourhood Teams. However, significant District Nursing workforce pressures continue to constrain community capacity, with mitigating support in place. Risks to achieving the planned increase in community capacity remain.
34	Primary Care Contract Optimisation		Delivery remains on track, with contractual access standards monitored and new Dental Contract measures implemented. Quality assurance review arrangements and the annual practice visit programme continue to develop. Targeted support in place to improve Diabetes Essential 8 Care processes, which are improving in line with plan.

**RAG based on progress against agreed deliverables, not outcome performance.*

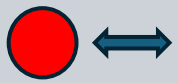
Operational Actions (continued)

ID	Priority Area	RAG Status*	Evidence of Progress – Achievements, Risks, Next Steps
35	6 Goals for UEC programme		The UEC Programme has moved into active delivery across all three workstreams, supported by strengthened governance, performance oversight and accountability, aligned to the wider Community by Design programme. While improvements in performance are still emerging, the focus for Q3 is to maintain momentum and ensure the changes being implemented translate into meaningful improvements in flow, discharge performance, admission avoidance and front-door pressures.
37	Medicine Clinical Board Reorganisation Ambitions		First-phase medicine reorganisation ambitions remain on track. Closure of W2 in process of de-escalation, evening consultant cover for AMRATZ is in place from October, and work is progressing to increase MSDEC take and develop the acute frailty model. Further work is underway on acute referrals, patient flow and winter capacity.
38	National Optimal Cancer Pathways		A revised cancer governance structure is being implemented to strengthen delivery of NOP implementation, SCP 75% standards and respond to the recommendations presented by the Audit Wales Cancer report. Performance meeting structure has been refreshed to have 3 meetings each week at different levels of granularity ranging from individual patient updates through to providing executive assurance and confirmation on trajectories.
39	Theatre Utilisation Programme		In-theatre utilisation remained at 77% in September 2026, in line with the Q2 trajectory.
40	Outpatient Improvement Programme		Outpatient improvement activity during Q2 has focused on a number of related productivity and efficiency initiatives. The UHB Q2 DNA rate is 9.5%, with an initiative currently being rolled out to reduce DNAs. In addition, a UHB-wide exercise is underway to increase SOS pathways through conversion of patients from FUNB, which is expected to deliver an additional 17,000 SOS pathways by the end of the financial year.

NOTE - Action ID 36 is captured as part of a broader strategic portfolio action (ID 2) so not updated here

**RAG based on progress against agreed deliverables, not outcome performance.*

Operational Actions (continued)

ID	Priority Area	RAG Status*	Evidence of Progress – Achievements, Risks, Next Steps
41	Integrated AHP Pathways		The OCP has been launched and consultation completed, with the revised structure now finalised. Work is underway to align roles to the new structure, with transition expected to commence early in the new year. The action remains Amber while the required HR processes are progressed.
42	Diagnostic Stewardship Programme		Four priority workstreams have been agreed, including development of an infographic to highlight the cost and volume of commonly requested diagnostics. Initial improvement opportunities have also been identified within ED diagnostic pathways for further exploration.
45	Neurodevelopmental Services Transformation		Options for transforming Neurodevelopmental services continue to be explored, with the English 'Right to Choose' model assessed as not cost effective. Recruitment of a substantive workforce was not approved due to non-recurrent funding. Work is aligning with the national move towards a needs-led model, not diagnosis-led, enabling better accessibility of support for children. Working towards compliance of national standards, which are still in draft form. Particular focus required on transitional ND pathways, working with MHCB as there is no current agreement for children who are awaiting assessment to transfer to adult waiting lists.
46	Mental health Improvement Programme		The Mental Health Improvement Programme has been reset with Shaping Change, consolidating activity into four coordinated programmes (*Service Transformation, Urgent Pathway Improvement, Culture & Improvement, and Data Intelligence & Performance*) with new governance and delivery arrangements in place. Early improvements include reduced out-of-area placements and bed days, improved flow, strengthened eating disorder governance and improved CTF compliance. Key risks/issues are capacity and competing operational pressures, change fatigue, limited dedicated funding, data/digital dependencies, and the need to complete partner mapping and confirm measurable outcomes, membership, detailed timelines and delivery plans.

NOTE - Action ID 43 & 44 are captured as part of a broader strategic portfolio action (ID 22 and 10, respectively) so not updated here

**RAG based on progress against agreed deliverables, not outcome performance.*

Full list of portfolio driven actions

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

ID	Portfolio	Area	Action
1	Clinical Services	CSP	Build the delivery roadmap for the clinical services plan and inform the operating model to ensure we deliver safe, effective, person-centred clinical care with timely access and sustainable services.
2		Community By Design	Launch the Community by Design Programme and develop a clear articulation of the role and phasing (over 1-, 2-and 5-year time horizons) in delivering relevant elements of the Clinical Services Plan (CSP), in particular the Enabling Health and Wellbeing domain of care.
3		Regional Planning (SEW)	Work collaboratively at a SEW regional level to realise the agreed 26-27 deliverables of the RJC
4		Velindre	Agreed agree a future model of care for cancer across CAVUHB & Velindre, with defined workstreams and a phased delivery plan in place.
5		Specialised Services	Strengthen the sustainable specialised services provision through planning in partnership with SBUHB and working with commissioners.
6	Population Health	Vaccination	Plan and deliver interventions to improve public and staff vaccination uptake
7		Healthy weight	Begin to implement a whole system approach to healthy weight through the Good Food and Movement Framework (2024-2030)
8		Tobacco Control	Plan and deliver interventions to reduce smoking prevalence in Cardiff and Vale
9		Diabetes	Improving diabetes prevention, diagnosis and management
10		Women's Health	Implementation of the Women's Health Plan for Wales
11	Quality	QMS	Continue to develop a health board-wide Quality Management System (QMS) that provides a structured approach to monitoring, auditing, and enhancing service quality
12		Quality Projects	Drive delivery of other priority quality projects in Shaping our Future Quality Excellence Programme - Recognition and Escalation of Acute Deterioration, Infection Prevention and Surveillance, Medication Governance and Safety and Lost to Follow Up
13		Quality	Refresh of the UHB Patient Safety, Quality and Experience Framework
14		Quality	Strengthen the availability of data for benchmarking and improvement
15		Value	Integrate Value based approaches across the organisation
16	People & Culture	P&C Plan	Refresh of P&C Plan to commence April 2026 to respond to and describe how our people and culture will be mobilised to support the delivery of a new model of care.
17		Workforce Organisational Redesign	Define and implement workforce elements of the Organisational Redesign
18		Leadership	Strengthen system leadership and management capability to create consistent, compassionate and accountable cultures.
19		Workforce planning	Develop workforce planning capability and capacity whilst using workforce data and insights to drive informed decision-making and future workforce sustainability.
20		Health & Wellbeing	Improve workforce health, wellbeing and availability
21	Infrastructure	Digital	Strengthen the Health Board's digital strategic direction and establish an operating model that enables delivery of Digital Foundations and the Clinical Services Plan
22			Implement key national and ministerial digital programmes that support improved access, interoperability and patient experience.
23			Digital enablers that support delivery of local and national imperatives Data Strategy and capabilities
24		Acute Estate	Improve utilisation and modernisation of the acute estate including disposal or demolition of under-utilised assets
25			Deliver a coordinated estate and service modernisation programme, including the UHW redevelopment vision, future dental model, urgent infrastructure response, ALAS relocation planning, and actions arising from JAICE accreditation.
26		Community Estate	Work in partnership to fully utilise multi agency estate opportunities, with an aim to provide care closer to home and better outcomes for patients
27	Future Generations	Future generations portfolio	Fully establish the Shaping Our Future Generations Portfolio including foundational economy, research and development, and innovation
28		Decarbonisation	Oversee development of our plan in response to the NHS Wales Decarbonisation Strategic Delivery Plan, supported by a clear communication plan and aligned delivery and accountability arrangements

Full list of non- portfolio driven actions

ID	Service Domain	Action
29	Organisational Redesign	To share operational redesign and future operating model across the organisation, and to develop an implementation plan and commence implementation
30	Length of Stay	To reduce organisational length of stay for non-elective medical admissions to peer-median levels (delivery of 1.3 day reduction)
31	Medicines Management	To undertake a comprehensive internal review of all NICE-approved medicines and technology spend to identify impact, risk, and opportunity, and implement any recommendations in year
32	Primary & Community Care	Transform End of Life Care services through our Macmillan partnership
33		Increase the number of people supported through Enhanced Community Care
34		Optimise primary care contracts and assurance mechanisms
35	UEC	Deliver the agreed 2026/27 actions of our 6 Goals for Urgent and Emergency Care Programme
36		Ensure integration between primary and secondary care through our ICCS and Community By Design Programme *(*Captured as part of Action ID 2)*
37		Deliver our medicine reorganisation ambitions
38	Planned Care & Cancer	Implement the National Optimum Cancer Pathways
39		Deliver the agreed 2026/27 actions of our theatre improvement programme to increase utilisation
40		Deliver our outpatient improvement programme
41	Diagnostics & Therapies	Develop integrated AHP pathways of care and leadership
42		Deliver the agreed 2026/27 actions of our Diagnostic Stewardship Programme
43		Delivery of the agreed 2026/27 actions of our digital transformation agenda across diagnostics *(*Captured as part of Action ID 22)*
44	Women & Children's	Delivering and evaluating our Women's Hub Pathfinder *(*Captured as part of Action ID 10)*
45		Evaluating and transforming our approach to Neurodevelopmental services
46	Mental Health	Deliver the agreed 2026/27 actions of our mental health improvement programme

RAG Assessment Definitions

RAG ratings are based on progress against agreed actions and planned deliverables rather than performance outcomes, providing a forward-looking view of delivery trajectory

RAG Rating	Assessment Criteria
Green	Delivery is progressing as planned • All quarterly deliverables met • Any issues are minor and being managed locally • High confidence in achieving future deliverables
Amber	Delivery is achievable but requires active management • One or more quarterly deliverables delayed or partially met • Identified risks or dependencies that may affect future delivery • Mitigating actions in place but not yet fully resolved • Delivery remains achievable but with reduced confidence
Red	Delivery is under significant pressure and requires review or reset • One or more quarterly deliverables not achieved • Progress is materially behind plan or blocked by major dependencies • Mitigations are insufficient to recovery delivery within current plans
Black	Action is not currently being progressed due to an agreed strategic decision • Delivery has been intentionally paused, stopped, or de-scoped • Decision is linked to strategic change, external dependency, or re-prioritisation N.B. Black status must be agreed at SRO/ Portfolio/ Programme level

References

This section provides a single, reliable reference point for key supporting documents.

- Annual Plan 2026-27
- Annual Plan 2026-27 Supporting Evidence Pack
- NHS Wales Planning Framework 2026 to 2029
- NHS Wales Performance Framework 2026-2027

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Cardiff and Vale University Health Board



Shaping Our Future

Wellbeing

Report Title: *(needs to match agenda)*	Mental Health & Community Information System		Agenda Item No:		3.1
Meeting:	F&P	Public	X	Meeting Date:	21/10/26
		Private			
Lead Executive Title:	David Thomas, Director of Digital & Health Intelligence				
Report Author/s Title:	Olga Rachello. Senior Project Manager				

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).*

There is a significant strategic, operational, clinical and financial risk associated with the current Civica PARIS Electronic Patient Record system reaching the end of its contract term (2029) and supporting infrastructure lifecycle (2028). The Health Board must procure and implement a replacement Electronic Patient Record solution within a constrained timeframe to avoid the loss of access to over 20 years of clinical records and support for approximately 176 Community, Mental Health and Therapy services.

Delay in approvals would materially reduce the available implementation window, increase delivery risk, potentially require substantial investment in ageing PARIS infrastructure (estimated at approximately £800,000), and jeopardise the Health Board's ability to safely complete migration before March 2029.

Furthermore, Welsh Government has allocated approximately **£1.9 million** to the programme in the current financial year (2026/27), which must be committed and spent by **31 March 2027**. Any delay in obtaining the necessary organisational approvals and completing the procurement process would compromise the programme's ability to utilise this funding within the required timeframe, creating a risk that the allocation could be lost and adversely impacting the project on a number of fronts:

- Any reduction in the estimated 24-month delivery window risks compromising the safe and secure delivery of the implementation.
- Approval delays will compromise the ability to complete procurement by the end of the current financial year, entailing the loss of over £1 million allocated Welsh Government funding.
- The consequent substantial underspend of allocated funds for the current financial year will likely result in a reduction of Welsh Government funding for Year 2 (2027/28) and Year 3 (2028/29), thus compromising the project's ability to cover costs necessary for its successful delivery.

F&P approval is therefore required to enable timely contract award, programme mobilisation and mitigation of the clinical, operational, financial and information governance risks associated with continued reliance on the existing PARIS platform.

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**	X	**Information/Noting**	

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

F&P is requested to:

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 £514,000 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) Support 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).

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

Where *it's been:*	*VBRG 01/07/26, VBRG 02/09/26*
When *it went:*	
What *decision was made:*	*Approval of progression of the MHCS Next Outline Business Case and commencement/continuation of the procurement process*

Main Report
Background & Current Situation

The CAVUHB Mental Health and Community System (MHCS) Programme is responsible for digitally enabling 176 clinical services mainly within the areas of Mental Health, Community and Therapies through the PARIS Electronic Patient Record (supplied by Civica). The PARIS system sustains operational processes and clinical information across about 30% of the Health Board's services with a historical depth of more than 20 years.

The current contract for the PARIS system runs until 31st March 2029.The supplier, Civica, does not currently have a long-term strategy for the future of PARIS – the risk is therefore that 176 services face loss of access to clinical notes and business processes beyond this date.

The MHCS business case sets out to procure and deploy a digital solution with key capabilities and additional functionality that the current PARIS EPR does not have and that reflects future business need, including mobile working and interoperability, within the challenging context of maintaining 176 live services whilst minimising impact on clinical and operational processes. Failure to procure, configure and implement the next generation tool across 176 clinical services would result in those services regressing 15-20 years in their model of delivery back to paper with the wholesale loss of 20+ years of clinical records.

The project team has identified a 24-month delivery window to enable the safe and secure rollout of the new system across the full scope of MHCS Programme services, commencing in April 2027. This timeline includes an estimated three-month pre-deployment phase covering system configuration, testing and workforce training. Consequently, the digital solution must be operational by January 2027 to support planned mobilisation and rollout.

To achieve this timescale, funding approval and completion of procurement are required by December 2026. Any delay in CAUHB approval of the proposed investment will directly and adversely impact the delivery feasibility and expose the MHCS Programme to the risk of loss of clinical notes and business-critical processes beyond March 2029.

In April 2025, Digital Health and Care Wales (DHCW) submitted an Outline Business (OBC) Case to Welsh Government seeking funding for Health Boards to implement a digital solution for Mental Health and Community Health services through its "Connecting Care" Programme. Partial funding via this route was secured for 2025/26 and invested in business readiness workstreams (Process Mapping and Data Migration Strategy development).

Whilst funding for implementation costs (Years 1-3) is being sought from Welsh Government, ongoing revenue investment for commercial costs from Year 4 (2029/30) onwards in the (projected) amount of £514,000 will come as a cost pressure to CAV. The successful delivery and long-term sustainability of the MHCS Programme are critically dependent on securing Welsh Government implementation funding for Years 1–3 alongside confirmed Cardiff and Vale UHB annual revenue funding from Year 4 onwards.

The current financial modelling indicates a recurrent cost pressure of approximately £514,000 per annum from 2029/30 onwards, subject to confirmation through procurement and final contract negotiations. This requirement reflects the anticipated cost of the replacement solution after allowing for existing PARIS expenditure and current assumptions regarding VAT treatment. Whilst the procurement exercise will provide greater certainty regarding the final commercial position, the report recognises that this represents an additional recurrent funding requirement that is not currently included within the Health Board's financial plan and will require consideration through future financial planning processes.

The case was presented to VBRG on 01/07/2026. The key outcome was that whilst the need for the programme was fully recognised and supported, the Group was unable to approve the business case in its current form due to the recurring revenue investment requirement of approximately **£514,000 per annum from Year 4 onwards**. VBRG's view was that the benefits and efficiencies required to offset this cost need to be owned and identified by the benefiting Clinical Boards rather than being treated as a corporate funding pressure.

As a result, VBRG requested further engagement with the scoped Clinical Boards to identify and agree efficiency opportunities and cashable benefits that could contribute towards closing this gap. A series of workshops were subsequently held involving Clinical Board representatives, Digital, Finance and other supporting colleagues to explore how the replacement system can support service transformation, productivity and efficiency improvements.

The discussions highlighted a number of opportunities that could be enabled through a next-generation EPR solution, including:

- Reduction in clinical documentation burden through Ambient Voice Technology (AVT).
- Improved patient-clinician interaction through reduced note-taking during appointments.
- Automated appointment booking, waiting list management and lost-to-follow-up monitoring.
- Improved interoperability and easier access to information across multiple systems.
- Enhanced reporting, audit, Subject Access Request (SAR) and data-quality processes.
- Workflow automation to reduce administrative effort and support operational efficiencies.

Clinical Board representatives furthermore highlighted that:

- The organisation currently faces substantial efficiency and savings requirements.
- Immediate identification of cash-releasing efficiencies is challenging prior to procurement and solution selection.
- Many technology-enabled benefits initially generate productivity improvements and increased clinical capacity rather than immediate cashable savings.
- A longer-term transformation programme will be required to realise financial benefits over the implementation and post-implementation period.

The workshops therefore concluded that a future commitment to benefits realisation and organisational transformation is more realistic than attempting to identify all specific cash-releasing efficiencies before procurement has been completed.

Whilst Clinical Board engagement identified a range of opportunities for productivity improvement, service transformation, capacity enhancement and operational efficiencies, these have not yet been translated into quantified cash-releasing savings plans. It is important to distinguish between expected

operational benefits and demonstrable financial savings. At this stage, it would not be appropriate to assume that the identified opportunities will fully offset the anticipated recurrent cost pressure. Further work will therefore be undertaken during procurement and implementation to develop robust benefits realisation plans, identify measurable outcomes and establish clear accountability for delivery across benefiting Clinical Boards.

The case was then scheduled to return for discussion at VBRG on 02/09/2026 with the following outcome delivered via Chair's Action:

I approve progression of the MHCS Next Outline Business Case and commencement/continuation of the procurement process.

The VBRG meeting scheduled to consider the case was stood down and, given the critical requirement to replace the existing PARIS system and the delivery timetable associated with that replacement, I do not consider it appropriate to delay the procurement process further pending resolution of the detailed recurrent funding arrangements.

This approval should not, however, be interpreted as confirmation that the recurrent affordability position has been fully resolved. The current business case identifies an estimated recurrent UHB funding requirement of £514k per annum from year 4. Supplier costs remain indicative at this stage and will be refined through the procurement process.

Clinical Board and Finance discussions regarding the allocation and delivery of the recurrent funding requirement should therefore continue as greater clarity emerges on the preferred supplier, functionality, implementation model and associated benefits.

Prior to contract award, the case must return through the appropriate governance route with an updated Financial Case and benefits plan setting out the confirmed recurrent cost, identified funding sources, proposed Clinical Board contributions and the extent to which these represent demonstrable cash-releasing benefits.

Approval through Chair's Action is therefore approval to progress the procurement, rather than unconditional approval to incur the eventual recurrent contractual commitment.

The requirement to replace PARIS remains a non-discretionary investment driven by clinical, operational, information governance and infrastructure risks. Whilst affordability considerations will continue to be developed and refined, delaying procurement until detailed financial savings plans are fully mature would materially increase programme risk and reduce the likelihood of achieving implementation before the March 2029 contract expiry date.

See Financial section below and Appendix 1 Section 5.1 for reference.

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

Appendix 1: MHCS Next Digital Transformation Business Case v1.2
Appendix 2: MHCS Business Case Costings inc VAT v1.2
Appendix 3: MHCS Next Project Update_F&P 22 Oct 2026 Slides

Strategic Alignment – Shaping Our Future Wellbeing:

Putting People First • Ensuring the continuation of an EPR enablement is key for putting our staff first by digitally supporting their day-to-day work • Mobile access would enable ease of access to relevant information where and when it is needed, and location-independent optimisation of workflow • Equipping community and therapies services with adequate digital tools shifts the focus from treatment to prevention and keeping people well outside the hospital, empowering them to live healthy lives and avoid preventable hospital stays	X	**Providing Outstanding Quality** • Investing in our community services will facilitate the engagement of these with our patient population, reaching people in their homes and in the areas where they live to support them through education and co-production of improved health outcomes • A fit-for-purpose EPR, with mobile access and interoperable with other digital systems across CAVUHB is key to enabling location-independent, safe, timely, accessible care where and when staff and patients need it • An EPR that produces robust reporting allows for continuous quality monitoring and improvement, and provides data for business improvement, cost-benefit and gap analyses for continuous financial optimisation of resources and workflows	X
Delivering in the Right Places • Investing in CAVUHB Community, Mental Health and Therapies digital enablement is harmonious with wider CaV DH&I ambitions to advance the Health Board's digital maturity to HIMSS EMRAM Level 3 and contributes to the key 2035 milestone of achieving 'a fully paperless environment with digital solutions supporting the entirety of the patient journey from beginning to end, spanning all care settings, including care at home' • An EPR with fully mobile, location independent access capability would uphold the principle of recording at the point of care • The Home First principle underling the last iteration of CAVUHB Shaping our Future Wellbeing Strategy cannot be upheld without equipping Community Services with adequate digital enablement to support their clinical work • Beyond the integration achieved by Mental Health, Community and Therapies services having a shared EPR, providing a system that has robust integration capability means transcending system siloes and facilitating the flow of data further across CAVUHB services	X	**Acting for the Future** • Providing services with a digital enablement that is fully mobile and interoperable directly advances CAVUHB's ambition to lower its carbon footprint, avoiding redundant use of paper for clinical notes and patient administration processes • An EPR with mobile access capability would allow for further reduction of carbon footprint eliminating the need for travel to specific locations for access, as well as the need to keep secondary paper-based systems for recording clinical and scheduling information • Avoiding the loss of a shared EPR across Community, Mental Health and Therapies Services directly promotes waste reduction by avoiding unwarranted duplication of work across different systems and mediums	X

Impact Assessment

Risk: Yes

Ref	Description of Risk	Likelihood of Risk (1-5)	Impact	Impact Severity (1-5)	Overall Risk Score	Mitigation Measures
R1	The reputation of the Health Board may be adversely affected by public perception of how historic health data is handled	1	Reputational damage for the Health Board	3	3	Ensure a considered IG compliant solution is implemented with adequate comms to the public.
R2	EPR provider unable to provide a fit for purpose solution within the required timescales	3*	Financial pressure due to having to incur costs of current solution alongside costs for replacement system	4	12	Ensure adequate contractual terms are in place with clear timescales and assurances for delivery.
R3	Health Board is unable to provide statutory data sets to WG if EPR system is not fit for purpose	1	Health Board in breach of legal requirements	4	4	Clear requirements on statutory data sets to be included in procurement
R4	EPR provider do not have capacity to support any work outside their off the shelf solution	3	Could result in delays to anticipated functionality	4	12	
R5	There may be local delays to recruitment (e.g. delays in approval etc.)	3	Could result in delays to the replacement EPR implementation.	4	12	Prepare all job descriptions and impact assessments in advance and taking any new roles through job evaluation as soon as possible Early escalation for Exec intervention
R6	National funding may not be available to purchase a suitable system/fund implementation	3	Project delivery will be catastrophically impacted.	5	15	Document funding options in the Business Case for consideration CAVUHB to make a decision on local funding
R7	Local funding may not be available to fund the revenue tail from Year 4 (BAU)	4	Project delivery will be catastrophically impacted.	5	20	Document funding options in the Business Case for consideration CAVUHB to make a decision on local funding
R8	A suitable commercial off the shelf Community and Mental Health	3	Could result in delays to the replacement	4	12	Undertake robust pre-market engagement Prioritise scope and requirements as to

	product may not be available to cover the areas defined as in scope		EPR implementation.			further define the Minimum Viable Product (MVP) Keep range of options open to include a development partnership
R9	The supplier post-contract award is unable to deliver a fit for purpose MVP	2	Will result in further procurement and further delays to a replacement EPR implementation.	4	8	Undertake robust pre-market engagement and due diligence on suppliers Undertake a robust procurement exercise with evaluation involving an MDT Strong specification and requirements
R10	Management of data migration strategy for legacy and current case load records not resolved before a new system is implemented	2	Integrity of data at risk Barrier to access historic records on current caseloads and for Subject Access Requests, Tribunals etc.	4	8	Data strategy undertaken early on in the implementation to ensure timely delivery
R11	Dependency on other areas in digital operations to facilitate implementation of the system	2	Could result in delays to the replacement EPR implementation.	4	8	Early involvement of other areas of digital services and engagement with UHB prioritisation process
R12	Risk of losing current staff and therefore up to 150+ years of specialist, collective expertise on the MHCS Programme due to significant impact on current roles (e.g. development role changing to be more analytic)	3	Loss of specialist MHCS knowledge within the new implementation	4	12	Ensure this risk is taken into account in workforce planning
R13	EPR vendor may lack specialised knowledge in Wales-specific Mental Health and/or Children's services legislation	3	This may compromise the Health Board's ability to comply with legislation or statutory returns	4	12	Receive assurance from supplier that any gaps in specialised knowledge will be filled Robust specification of requirements, Contract terms and SLA covering Welsh-specific aspects that supplier is contractually obliged to provide.

R14	Procurement and approvals phase may experience delays (Based on recent ABUHB procurement and approvals experience)	3	Delivery timeline is adversely impacted and may result in the need to recontract PARIS or enter an unsupported state	4	12	Close engagement with Procurement to identify any pre-procurement activity and documentation that can be prepared to facilitate procurement and approvals
R15	Engagement with SMEs for supplier response evaluation may experience delays	3	Delivery timeline is adversely impacted and may result in the need to recontract PARIS or enter an unsupported state	4	12	Early engagement with SMEs and clear communication regarding expected availability and time commitment

Safety: Yes

Quality and patient safety are at the heart of this initiative. Between 2023-2025 a number of Regulation 28 Prevention of Future Deaths notices have been issued to other Health Boards in Wales and NHS Trusts in England that cite lack of digital enablement for clinical services, lack of access to all available relevant clinical information by involved staff, or lack of integration among digital systems causing a fragmented landscape of siloed systems that make op to whole of a patient record, as contributory causes to patient deaths:

- Betsi Cadwaladr University Health Board Ref: 2023-0185
- NHS England | Derby and Burton Hospital | Royal Stoke University Hospital Ref: 2024-0528
- Surrey and Borders Partnership NHS Foundation Trust Ref: 2025-0027
- Swansea Bay University Health Board Ref: 2024-0224

This has been reflected in the Outline Business Case *Investment Objective 1. To digitally optimise the quality and safety of care, including the reduction of clinical risk and risk of mortality* (see **Appendix 1, Section 2.8 Investment Objectives**)

It is also noted among project benefits, as listed below (also see **Appendix 1, section 3.6.1.1 Identified Benefits**):

Ref.	Benefit
Ben1	**Improved quality and safety of care** Resulting from a more comprehensive clinical picture available to involved staff through effective interoperability of the EPR, as well as access to the patient record where and when it is needed though full mobile access
Ben6	**Improved staff safety** Full mobile access would allow for increased staff safety resulting from staff location being known to their team as well as smaller kit/devices to reduce risk of theft
Ben11	**Reduction in risk of preventable mortality and morbidity (Risk Adjusted Mortality Indicator)**

	See section 2.5.4 Regulation 28 Prevention of Future Deaths Reports detailing how lack of access to all available records and lack of interoperability among digital systems are found to be contributory factors to preventable deaths. In relation to societal benefits, the average economic cost of suicide is £1,458,136 per person, 135 people on average are affected by someone who takes their own life (Samaritans, 2022). It is worth stating but not possible to use due to the multiple factors related to suicide.

Financial: Yes

10-year project cost profile and funding requirements are summarised in the table below (also see **Appendix 1 Section 5.1**):

MH & Community	Programme				BAU								
	Year 1	Year 2	Year 3	Programme Total	Year 4	Year 5	5 Year Total	Year 6	Year 7	Year 8	Year 9	Year 10	10 Year Total
Costs	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Non Recurrent Costs													***0***
Implementation Staff	837	837	837	**2,511**	0	0	***2,511***	0	0	0	0	0	***2,511***
Supplier Costs (Implementation)	642	0	0	**642**	0	0	***642***	0	0	0	0	0	***642***
Existing Supplier Costs (PARIS)	231	231	255	**717**	0	0	***717***	0	0	0	0	0	***717***
Integration costs (Initial)		300	150	**450**			***450***						***450***
Recurrent Costs													
Supplier Costs (4575 licences)	268	535	803	**1,605**	803	803	***3,210***	803	803	803	803	803	***7,223***
Data Archiving			100	**100**	100	100	***300***	100	100	100	100	100	***800***
TOTAL NET COSTS	**1,977**	**1,903**	**2,144**	**6,025**	**903**	**903**	**7,830**	**903**	**903**	**903**	**903**	**903**	**12,343**
Funding Requirement													
WG Funding Request	*1,595*	1,533	1,731	***4,858***	*0*	*0*	***4,858***	*0*	*0*	*0*	*0*	*0*	***4,858***
UHB Funding Revenue (Budget for PARIS)	*231*	231	255	***717***	*255*	*255*	***1,227***	*255*	*255*	*255*	*255*	*255*	***2,502***
VAT reclaim	*152*	139	159	***450***	*134*	*134*	***717***	*134*	*134*	*134*	*134*	*134*	***1,386***
TOTAL FUNDING	***1,977***	***1,903***	***2,144***	***6,025***	***389***	***389***	***6,802***	***389***	***389***	***389***	***389***	***389***	***8,746***
Internal UHB Revenue Investment	*0*	*0*	*0*	***0***	*514*	*514*	*1,028*	*514*	*514*	*514*	*514*	*514*	*3,597*
TOTAL WG FUNDING AND SAVINGS	***1,977***	***1,903***	***2,144***	***6,025***	***903***	***903***	***7,830***	***903***	***903***	***903***	***903***	***903***	***12,343***

Welsh Government has allocated approximately £1.9 million to support programme mobilisation and implementation activity in 2026/27. Further implementation funding for Years 1-3 is being sought through national funding arrangements.

Current modelling identifies an estimated recurrent funding requirement of approximately £514,000 per annum from 2029/30 onwards, although this will be refined through the procurement process and final commercial negotiations. This recurrent cost pressure is not currently funded within the Health Board's medium-term financial plan and will require consideration through future financial planning arrangements.

Engagement with Clinical Boards has identified a range of potential productivity, efficiency and transformation benefits that could support mitigation of this cost pressure over time. However, these opportunities have not yet been developed into quantified cash-releasing savings plans and therefore cannot currently be relied upon to offset the additional expenditure.

Progression of the procurement process is necessary to maintain delivery of this essential replacement programme and should not be contingent upon completion of detailed Clinical Board savings plans. However, prior to contract award, an updated financial case will be presented through the appropriate

governance route confirming the final recurrent cost, identified mitigations, affordability position and remaining funding requirements.

Major risks related to lack of funding have also been noted in the Risk section above:

- R6a National funding may not be available to purchase a suitable system/fund implementation (partially mitigated by allocation of WB funding for FY 2026/27)
- R6b Local funding may not be available to purchase a suitable system/fund implementation

Workforce: Yes

Current workforce implications include the partial redirection of current MHCS Programme resources to support this initiative. This has been considered and approved by the MHCS Programme Board and is subject to ongoing adjustments to reflect business need, BAU demands and concurring initiatives.

The OBC has also included an augmentation of MHCS Programme workforce to enable the implementation. For further details and full workforce breakdown see **Appendix 1 Section 6.1.3.2 Project Team and Budget**.

Legal: Yes

The implementation would need to comply with any statutory requirements and GDPR guidelines relating to clinical record keeping. Advice will be sought from CAV UHB IG department.

The following risks have also been noted in the Risk section above:

- R3 Health Board is unable to provide statutory data sets to WG if EPR system is not fit for purpose
- R14 EPR vendor may lack specialised knowledge in Wales-specific Mental Health and/or Children's services legislation

Reputational: Yes

A reputational risk has been noted in the Risk section above:

- R1 The reputation of the Health Board may be adversely affected by public perception of how historic health data is handled

This risk will need to be mitigated by ensure a considered IG compliant solution is implemented with adequate comms to the public.

Socio Economic: Yes - *https://www.gov.wales/socio-economic-duty-guidance*

The Socio-Economic Duty impact of this proposal has been detailed in the Strategic Objectives of Shaping our Future Wellbeing section above, specifically points 2. Providing Outstanding Quality and 3. Delivering in the Right Places.

Equality & Health: Yes

We are currently investigating whether the proposals contained within the report necessitate the requirement for an EHIA to be undertaken.

Decarbonisation: Yes

Alignment with the organisation's decarbonization targets is noted in the Strategic Objectives of Shaping our Future Wellbeing section above, specifically in point 4. Acting for the Future.

It is also included in projected benefits, as outlined in the table below (also see **Appendix 1, section 3.6.1.1 Identified Benefits**):

Ref.	Benefit
Ben2	**Reduction in excess travel to access EPR** Mobile access enables staff to spend less time travelling back to base/CAV sites specifically to access the EPR
Ben8	**Reduction of hardware and electric costs, CO2 emissions** A Cloud based solution would allow for a reduction of costs connected to hardware and its storage

Welsh Language: Yes

The current MHCS Programme digital enablement strives to be fully compliant with the Welsh Language (Wales) Measure 2011 and this initiative would ensure a continuation of this compliance.

Staffing Requirements

Mental Health System Only

Comments	Staff type	Grade and Point of Scale	WTE	Pay Cost inc Ers	Year 1 (Nov-25 - Mar-26)	Year 2 (Apr-26 - Mar-27)
	Project Manager	XR06.AVE	1	54,845	54,845	54,845
	Project Support Officers	XR04.AVE	1	40,326	40,326	40,326
	Implementation Officer	XR04.AVE	1	40,326	40,326	40,326
	Senior System Developer	XR06.AVE	2	54,845	109,690	109,690
	System Developer	XR05.AVE	2	50,723	101,446	101,446
	Senior Information Officer	XR06.AVE	1	54,845	54,845	54,845
	Business Analyst	XR06.AVE	1	54,845	54,845	54,845
	Integration Manager	XR07.AVE	1	67,712	67,712	67,712
	Testing Manager	XR07.AVE	1	67,712	67,712	67,712
	Data Migration Manager	XR07.AVE	1	67,712	67,712	67,712
Total Implementation Staff Cost			**12**		**659,459**	**659,459**

All

Comments	Staff type	Grade and Point of Scale	WTE	Pay Cost inc Ers	Year 1 (Nov-25 - Mar-26)	Year 2 (Apr-26 - Mar-27)
	Senior Project Manager	XR07.AVE	1	67,712	67,712	67,712
	Project Support Officer	XR04.AVE	1	40,326	40,326	40,326
	Implementation Officer	XR04.AVE	1	40,326	40,326	40,326
	Senior System Developer	XR06.AVE	2	54,845	109,690	109,690
	System Developer	XR05.AVE	2	50,723	101,446	101,446
	Senior Information Officer	XR06.AVE	1	54,845	54,845	54,845
	Business Analyst	XR06.AVE	4	54,845	219,380	219,380
	Integration Manager	XR07.AVE	1	67,712	67,712	67,712
	Testing Manager	XR07.AVE	1	67,712	67,712	67,712
	Data Migration Manager	XR07.AVE	1	67,712	67,712	67,712
Total Implementation Staff Cost			**15**		**836,861**	**836,861**

Year 3 (Apr-27 - Mar-28)	Year 4 (Apr-28 - Mar-29)	Year 5 (Apr-29 - Mar-30)
54,845		
40,326		
40,326		
109,690		
101,446		
54,845		
54,845		
67,712		
67,712		
67,712		
659,459	**0**	**0**

Year 3 (Apr-27 - Mar-28)	Year 4 (Apr-28 - Mar-29)	Year 5 (Apr-29 - Mar-30)
67,712		
40,326		
40,326		
109,690		
101,446		
54,845		
219,380		
67,712		
67,712		
67,712		
836,861	**0**	**0**

MH & Community	Programme		
Funding requirement	**Year 1**	**Year 2**	**Year 3**
Costs	**£'000**	**£'000**	**£'000**
WG Funding Request	*1,595*	1,533	1,731
UHB Funding Revenue (Budget for PARIS)	*231*	231	255
Internal UHB Revenue Investment	*0*	0	0
VAT reclaim	*152*	139	159
TOTAL FUNDING	***1,977***	***1,903***	***2,144***

BAU							
Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	10 Year Total
£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
0	*0*	*0*	*0*	*0*	*0*	*0*	***4,858***
255	*255*	*255*	*255*	*255*	*255*	*255*	***2,502***
514	*514*	*514*	*514*	*514*	*514*	*514*	***3,597***
134	*134*	*134*	*134*	*134*	*134*	*134*	***1,386***
903	***903***	***903***	***903***	***903***	***903***	***903***	***12,343***

MH & Community	Programme			
	Year 1	Year 2	Year 3	Programme Total
Costs	**£'000**	**£'000**	**£'000**	**£'000**
Non Recurrent Costs				
Implementation Staff	837	837	837	**2,511**
Supplier Costs (Implementation)	642	0	0	**642**
Existing Supplier Costs (PARIS)	231	231	255	**717**
Integration costs (Initial)		300	150	**450**
Recurrent Costs				
Supplier Costs (4575 licences)	268	535	803	**1,605**
Data Archiving			100	**100**
TOTAL NET COSTS	**1,977**	**1,903**	**2,144**	**6,025**
Funding Requirement				
WG Funding Request	*1,595*	1,533	1,731	***4,858***
UHB Funding Revenue (Budget for PARIS)	*231*	231	255	***717***
VAT reclaim	*152*	139	159	***450***
TOTAL FUNDING	***1,977***	***1,903***	***2,144***	***6,025***
Internal UHB Revenue Investment	*0*	*0*	*0*	***0***
TOTAL WG FUNDING AND SAVINGS	***1,977***	***1,903***	***2,144***	***6,025***

BAU							
Year 4	Year 5	5 Year Total	Year 6	Year 7	Year 8	Year 9	Year 10
£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
0	0	***2,511***	0	0	0	0	0
0	0	***642***	0	0	0	0	0
0	0	***717***	0	0	0	0	0
		450					
803	803	***3,210***	803	803	803	803	803
100	100	***300***	100	100	100	100	100
903	**903**	**7,830**	**903**	**903**	**903**	**903**	**903**
0	*0*	***4,858***	*0*	*0*	*0*	*0*	*0*
255	*255*	***1,227***	*255*	*255*	*255*	*255*	*255*
134	*134*	***717***	*134*	*134*	*134*	*134*	*134*
389	***389***	***6,802***	***389***	***389***	***389***	***389***	***389***
514	*514*	*1,028*	*514*	*514*	*514*	*514*	*514*
903	***903***	***7,830***	***903***	***903***	***903***	***903***	***903***

10 Year Total
£'000
0
2,511
642
717
450
7,223
800
12,343
4,858
2,502
1,386
8,746
3,597
12,343

Software costs

Supplier Costs (MH element - 1975 licences)	202	404	606	**1,212**
Supplier Costs (Community - 2600 licences)	66	131	197	**393**
	268	535	803	**1,605**

606	606	***2,424***	606	606	606	606	606	***5,454***
197	197	***786***	197	197	197	197	197	***1,769***
803	803	***3,210***	803	803	803	803	803	***7,223***

NPV	Year 1	Year 2	Year 3
Costs	**£'000**	**£'000**	**£'000**
Implementation Staff	837	837	837
Supplier Costs (Implementation)	642	0	0
Existing Supplier Costs (PARIS)	231	231	255
Integration costs (Initial)		300	150
Supplier Costs (4575 licences)	268	535	803
Data Archiving			100
Total Costs Annual	***1,977***	***1,903***	***2,144***
Total Costs Cumulative	**1,977**	**3,880**	**6,025**
Discount Factor @ 3.5%	*1.000*	*0.966*	*0.934*
TOTAL FUNDING	***1,977***	***1,839***	***2,002***
TOTAL WG FUNDING AND SAVINGS	***1,977***	***3,816***	***5,818***

0.965	0.931225
0.966	0.93219

0	1
1	0.966184
2	0.933511
3	0.901943
4	0.871442
5	0.841973
6	0.813501
7	0.785991
8	0.759412
9	0.733731
10	0.708919

Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	10 Year Total
£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
0	0	0	0	0	0	0	***2,511***
0	0	0	0	0	0	0	***642***
0	0	0	0	0	0	0	***717***
							450
803	803	803	803	803	803	803	***7,223***
100	100	100	100	100	100	100	***800***
903	***903***	***903***	***903***	***903***	***903***	***903***	***12,343***
6,927	**7,830**	**8,732**	**9,635**	**10,538**	**11,440**	**12,343**	
0.902	*0.871*	*0.842*	*0.814*	*0.786*	*0.759*	*0.734*	
814	***787***	***760***	***734***	***709***	***685***	***662***	***10,970***
6,632	***7,418***	***8,178***	***8,913***	***9,622***	***10,307***	***10,970***	

0.898632 0.86718 0.836829 0.80754 0.779276 0.752001 0.725681
0.899563

1.000 0.966 0.934 0.902 0.871 0.842 0.814 0.786

0.759 0.734 0.709

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Cardiff and Vale University Health Board

Shaping Our Future
Digital Services

MHCS Next Project

Mental Health & Community Information System (MHCS) Programme

David Thomas, Director of Digital & Health Intelligence

Olga Rachello, Senior Project Manager

F&P 21/10/2026

Shaping Our Future
Digital Services

MHCS Next Context

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Cardiff and Vale University Health Board

- Current contract for the PARIS EPR system runs until 31st March 2029.The supplier, Civica, does not currently have a long-term strategy for the future of PARIS – the risk is therefore that 176 services face loss of access to clinical notes and business processes beyond this date. Civica recently bid in AB MH EPR Procurement with products other than PARIS.

- 2029/30 hardware refresh cost ~£800,000.

- Project team has identified a 24-month delivery window to enable the safe and secure rollout of the new system across the full scope of MHCS Programme services, commencing in April 2027. This timeline includes an estimated three-month pre-deployment phase covering system configuration, testing and workforce training. Consequently, the digital solution must be operational by January 2027 to support planned mobilisation and rollout.

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Digital Services

Do Nothing: Critical Risks

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- Loss of access to clinical notes and operational workflows, effectively rendering services **unable to safely deliver and coordinate care**
- Clinical risks and impact on quality of care, including **risk of preventable deaths**
- Loss of **20 years' worth of digital transformation** including data-driven decision-making
- Risk of Information Governance breaches and fines
- Need for **additional clerical workforce capacity**
- Significant increase in **paper, printing, and postage costs**.
- Deterioration in staff experience and productivity
- Lack of national and local strategic fit (e.g. **Integrated Community Care System**)

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Digital Services

MHCS Next Full Costs

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Cardiff and Vale University Health Board

MH & Community	Programme				BAU								
	Year 1 26/27	Year 2 27/28	Year 3 28/29	Programme Total	Year 4 29/30	Year 5 30/31	5 Year Total	Year 6 31/32	Year 7 32/33	Year 8 33/34	Year 9 34/35	Year 10 35/36	10 Year Total
Costs	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Non Recurrent Costs													
Implementation Staff	837	837	837	**2,511**	0	0	***2,511***	0	0	0	0	0	***2,511***
Supplier Costs (Implementation)	642	0	0	**642**	0	0	***642***	0	0	0	0	0	***642***
Existing Supplier Costs (PARIS)	231	231	255	**717**	0	0	***717***	0	0	0	0	0	***717***
Integration costs (Initial)		300	150	**450**			***450***						***450***
Recurrent Costs													
Supplier Costs (4575 licences)	268	535	803	**1,605**	803	803	***3,210***	803	803	803	803	803	***7,223***
Data Archiving			100	**100**	100	100	***300***	100	100	100	100	100	***800***
TOTAL NET COSTS	**1,977**	**1,903**	**2,144**	**6,025**	**903**	**903**	**7,830**	**903**	**903**	**903**	**903**	**903**	**12,343**
Funding Requirement													
WG Funding Request	*1,595*	1,533	1,731	***4,858***	*0*	*0*	***4,858***	*0*	*0*	*0*	*0*	*0*	***4,858***
UHB Funding Revenue (Budget for PARIS)	*231*	231	255	***717***	*255*	*255*	***1,227***	*255*	*255*	*255*	*255*	*255*	***2,502***
VAT reclaim	*152*	139	159	***450***	*134*	*134*	***717***	*134*	*134*	*134*	*134*	*134*	***1,386***
TOTAL FUNDING	***1,977***	***1,903***	***2,144***	***6,025***	***389***	***389***	***6,802***	***389***	***389***	***389***	***389***	***389***	***8,746***
Internal UHB Revenue Investment	***0***	***0***	***0***	***0***	***514***	***514***	***1,028***	***514***	***514***	***514***	***514***	***514***	***3,597***
TOTAL WG FUNDING AND SAVINGS	***1,977***	***1,903***	***2,144***	***6,025***	***903***	***903***	***7,830***	***903***	***903***	***903***	***903***	***903***	***12,343***

National Landscape

Connecting Care Health - EHR Implementations

	Mental Health EHR	Community Health EHR	Funding Position
ABUHB	Mental Health Rio procured; contract signed May 2026; planned go-live March 2027.	No Community Health procurement currently planned.	Funding critical for ongoing implementation
BCUHB	joint Mental Health procurement completed in late 2025; approval to announce preferred supplier received May 2026; currently in standstill with announcement expected mid-June.	BCUHB is developing a Community Health OBC	Funding critical for ongoing implementation (via Pathfinder BC)
CAVUHB	Developing an OBC for a combined Community and Mental Health system to replace PARIS.		Funding critical for procurement to begin
CTMUHB	As BCUHB above	CTM undertaking early Community Health options appraisal.	Funding critical for ongoing implementation (via Pathfinder BC)
HDDUHB	No Mental Health procurement currently planned.	Leading Community Health procurement	Funding critical for procurement to begin
PTHB	Combined Community and Mental Health system procured; Access/Rio awarded; working to implement and migrate away from CareDirector by March 2027.		Funding critical for initiating implementation
SBUHB	Access/Rio procured for paper-based Mental Health teams; configuration and data migration ongoing for users in integrated teams using WCCIS;	Business case being developed for remaining Community and Mental Health scope.	Funding critical for ongoing implementation

Shaping Our Future
Digital Services

Welsh Government Funding

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Cardiff and Vale University Health Board

Welsh Government has allocated approximately **£1.9 million** to the programme in the current financial year (2026/27), which must be committed and spent by **31 March 2027**. Any approval delay will jeopardise the success of the project as follows:

- Any reduction in the estimated 24-month delivery window risks compromising the safe and secure delivery of the implementation.
- Approval delays will compromise the ability to complete procurement by the end of the current financial year, entailing the loss of over £1 million allocated Welsh Government funding.
- The consequent substantial underspend of allocated funds for the current financial year will likely result in a reduction of Welsh Government funding for Year 2 (2027/28) and Year 3 (2028/29), thus compromising the project's ability to cover costs necessary for its successful delivery.

F&P approval is therefore required to enable timely procurement, programme mobilisation and mitigation of the clinical, operational, financial and information governance risks associated with continued reliance on the existing PARIS platform.

Shaping Our Future
Digital Services

CAV Governance Calendar

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Cardiff and Vale University Health Board

VBRG Submission	VBRG	SLT Sumbission	SLT	F&P Submission	F&P	Board Submission	Board
18 March 2026	01 April 2026	02 April 2026	16 April 2026	08 April 2026	22 April 2026	No April Meeting	No April Meeting
22 April 2026	06 May 2026	23 April 2026	07 May 2026	06 May 2026	20 May 2026	14 May 2026	28 May 2026
20 May 2026	03 June 2026	30 April 2026	14 May 2026	03 June 2026	17 June 2026	No June meeting	No June meeting
17 June 2026	01 July 2026	07 May 2026	21 May 2026	08 July 2026	22 July 2026	16 July 2026	30 July 2026
22 July 2026	05 August 2026	21 May 2026	04 June 2026	No August meeting	No August meeting	No August meeting	No August meeting
19 August 2026	**02 September 2026**	04 June 2026	18 June 2026	02 September 2026	16 September 2026	10 September 2026	24 September 2026
23 September 2026	07 October 2026	18 June 2026	02 July 2026	**08 October 2026**	**22 October 2026**	No October meeting	No October meeting
21 October 2026	04 November 2026	25 June 2026	09 July 2026	04 November 2026	18 November 2026	**12 November 2026**	**26 November 2026**
18 November 2026	02 December 2026	02 July 2026	16 July 2026	No December meeting	No December meeting	No December meet	No December meet
16 December 2026	06 January 2027	23 July 2026	6 August 2026	06 January 2027	20 January 2027	14 January 2027	28 January 2027
20 January 2027	03 February 2027	30 August 2026	13 August 2026	03 February 2027	17 February 2027	No February meet	No February meet
17 February 2027	03 March 2027	06 August 2026	20 August 2026	03 March 2027	17 March 2027	11 March 2027	25 March 2027
		20 August 2026	03 Sept 2026				
		09 Oct 2026	**15 Oct 2026**				

Report Title: *(needs to match agenda)*	Monthly Monitoring Return – Month 5		Agenda Item No:		4.1
Meeting:	Finance and Performance Committee	Public	x	Meeting Date:	21st October 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 August 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 31st August 2026



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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.

Following the response from Welsh Government, the Health Board submitted a letter on the 29th May 2026 confirming its intention to de-risk the financial plan by the end of Quarter 2.

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.

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	68.759
2026/27 Demand/Cost Growth/Improvement	54.690
2026/27 Increase in Contribution to Welsh Risk Pool	21.500
Deficit	**144.949**
Additional Allocations	(15.881)
Savings Plans	(42.521)
Initial Planned Deficit	**86.547**

The submitted plan projects a deficit for the financial year, meaning the UHB will not meet its statutory requirement to deliver a balanced financial plan over a three-year rolling period. Consequently, the plan cannot receive Ministerial approval.

The financial monitoring returns have been prepared within the framework of the UHB's Annual Plan, which includes a planning deficit of £86.5m for 2026-27. This report details the financial position of the UHB for the period ending 31st August 2026.

A full commentary has been provided to cover the tables requested for the month 5 financial position.

At Month 5 the UHB is reporting an overspend of £43.1m, which is £7.1m over plan

The reported overspend of £43.1m comprises a £36.1.m planned deficit (representing five twelfths of the £86.5m outlined in the UHB's Financial Plan) a £9.6m shortfall against the savings plan, partially offset by a £(2.5)m operational surplus.

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 5 for which the following should be noted:

- Line 12 reconciles to the Health Board's £86.5m submitted plan 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 an overspend of £43.1m year-to-date, which is a deterioration of £7.1m from the submitted plan.
- The deterioration is driven by a £9.6m savings gap, £(7.0)m unplanned spend reductions and £4.4m 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 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 concerns regarding the current level of assurance associated with delivery of the savings target and recognises the requirement to accelerate progress in identifying and developing fully assured savings schemes.

Whilst detailed plans to eliminate the remaining savings gap have not yet been fully developed at month 5, work is ongoing through the established financial recovery and accountability arrangements to identify further savings opportunities, strengthen existing schemes and reduce reliance on unidentified mitigations. This work is being supported through Executive-led turnaround meetings with each of the UHB's Clinical Boards and continues to be reported through the Board's 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 projected for 2027/28 is currently assessed at £86.5m. This assumes the 2026/27 plan is fully delivered on a recurrent basis with no recurrent impact from current unplanned cost pressures and unplanned cost reductions.

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 £17.9m against its core £42.5m savings target. When considering the forecast operational position, this is quantified as a risk of £0.7m 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 £43.1m, consistent with the analysis set out in the annual operating plan (Table A).

The UHB's Annual Plan includes a deficit of £86.5m. At Month 5, the reported deficit is £7.1m adverse to the submitted plan, primarily due to a £23m 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 5, 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 five twelfths of the projected £1.4m year-end underspend across JCC, LHBs and Velindre reflected in the reported position at Month 5. In addition, the Health Board reported higher patient care income, 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 2: Summary Financial Position for the period ended 31st August 2026

	Plan PTD (£m)	PTD (£m)	PTD Variance to Plan (£m)	Plan YTD (£m)	YTD (£m)	YTD Variance to Plan (£m)
Draft Plan	10.9	10.9	0.0	53.8	53.8	0.0
Quality Efficiency Improvement Plans - Savings	3.7	2.2	1.5	17.7	8.2	9.6
Operational Variance	0.0	1.1	1.1	0.0	2.5	2.5
Clinical/Service Board Variance	**7.2**	**7.6**	**0.4**	**36.1**	**43.1**	**7.1**

The Month 5 deficit of £43.1m comprised of the following:

- £36.1m planned deficit (five twelfths of the £86.5m planning deficit)
- £9.6m CRP deficit
- (£2.5m) surplus operational variance against plan.

The operational surplus of (£2.5) is primarily driven by the following issues:

Unplanned Cost Pressures - £4.4m

- Medicine endoscopy insourcing - £1.0 m
- Mental Health Out of Area Patients - £1.1m
- Specialist Medical Locum Usage (covering gaps due to restricted duties, rota gaps, interventional cardiologists) - £0.4m
- Specialist Private Patient Activity Reductions - £0.6m
- New Resident Doctors contract - £0.2m
- 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 - £(6.9)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 - £(0.9)m
- Vacancies across the Health Board - £(4.3)m
- Specialist Medical Locum usage mitigating actions - £(0.9)m
- LHB Expenditure Reduction & JCC Commissioner position - £(0.6)m

Table 3: Summary of reasons for variance to Financial Plan including Forecast

Operational Pressure & Savings Shortfall	Operational Variance YTD £m	Operational Variance Forecast £m
Endoscopy Insourcing and Recruitment Outside of Plan	1.0	1.4
Mental Health Out of Area Placements	1.1	2.2
Specialist Medical Locum Usage	0.4	0.8
Specialist private patient activity reductions	0.6	0.7
Resident Doctors Contract	0.2	1.2
LHB Expenditure Reduction & JCC Commissioner	(0.6)	(1.4)
Medicines Management (Primary Care & NICE)	(0.9)	(2.8)
Pay Vacancies across the Health Board	(4.3)	(9.3)
Savings Shortfall	9.6	23.0
Sub-Total Surplus/Deficit	**7.1**	**15.8**

It is expected that all unplanned cost pressures arising in 2026/27 will have corresponding mitigations identified to deliver the submitted £86.5m planned 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.

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.

The Health Board acknowledges that the deadline of the 30 June 2026 (end of Quarter One) for all savings that were assumed in the plan, to meet the required Green/Amber classification has not been met. The intention remains to derisk the 2026/27 financial plan as soon as possible.

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 4 below:

Table 4 – Movement in Resource Limit Assumptions following submission of the MDS as at 31st August 2026

Movement in Resource Limit Assumptions following submission of the MDS as at 31st August 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	
Movement in Resource Limit Assumptions following submission of the MDS		30.539
Total Resource Limit Assumptions Year to Date £m		**1,548.859**

Expenditure

The following table sets out the key expenditure movements from the prior month's MMR submission. As part of the ongoing process improvement and data quality review, the categorisation of Clinical Board has been reviewed and has resulted in a correction to the categorisation of forecast expenditure during Months 4 & 5. This has resulted in a number of reclassifications between expenditure categories; however, these changes are presentational in nature and do not impact the overall reported financial position. All Clinical Boards have now completed the review of their categorisation of expenditure.

Expenditure Category	Narrative
Primary Care Contractor (excl. drugs, incl. NRL expenditure)	The forecast for Primary Care contractor expenditure has been reviewed during the month 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 forecast pay position has improved materially during the month. While part of this movement relates to reclassifications arising from the review of Clinical Board expenditure categorisation, the forecast also reflects the new Resident Doctors contract and recruitment plans in progress. The recurrent impact of the Resident Doctors contract is being assessed. 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.
Provider Services - Non Pay (excluding drugs & depreciation)	An additional £1.2m of additional savings schemes have been identified during Month 5 which will have been reflected in the ledger, the planned mitigations are reported against non-pay until identified.
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.
Healthcare Services Provided by Other NHS Bodies	The forecast movement of £5.8m within Healthcare Services Provided by Other NHS Bodies is primarily attributable to the Commissioning position, reflecting updated assumptions for NHS body commissioning expenditure. 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	No additional comments
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 May 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 £(9.3)m arising from continued vacancy levels following recent recruitment. The recurrent impact is currently being assessed. £0.4 m unplanned cost pressure to Month 5 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 £0.2m to Month 5 with a forecast £1.2m to the end of the year. The recurrent position is being assessed.
Provider Services - Non Pay (excluding drugs & depreciation)	£14.4m additional spend associated with various in-year funding/income. £1m Endoscopy insourcing cost pressure to Month 5 with a total forecast of £1.2m until insourcing arrangements cease (recruitment to be in place from Q3 onwards) £0.6m pressure to Month 5 associated with Specialist Private Patient Activity reductions. The pressure is expected to slow before the end of the year with a forecast of £0.7m. £10.7m 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 £0.6m 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	£1.1m unplanned cost pressure to Month 5 associated with Mental Health Out of Area placements. The forecast has been updated to reflect a full-year adverse financial impact of £2.2m 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 August as follows:

- Additional Clinical Services - £0.02m – Primarily providing specialist cover for high-acuity patients.
- Administrative and Clerical - £0.02m – Primarily providing specialist cover for Clinical Coding Vacancies.
- Estate and Ancillary- -£0.02m primarily relating to security costs.
- The in-month credit of £0.003m recorded against Allied Health Professionals relates to an agency expenditure transfer made during the month from Other Staff Groups to Contractual Clinical Services, where the associated costs are directly recharged to another Health Board.

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 5, the UHB has identified £24.6m of Green and Amber-rated savings, representing 57.9% of the core £42.5m savings target and leaving a remaining shortfall of £17.9m. The value of identified Green and Amber savings has increased by £1.2m from the £23.4m reported at Month 4, reflecting continued progress in the

development and assurance of savings schemes. The UHB has identified a further 20.0m 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 £19.3m, resulting in a recurrent shortfall of £23.2m 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 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 £20.0m which are identified include additional measures agreed by the Executive Team, principally:

- a 370 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

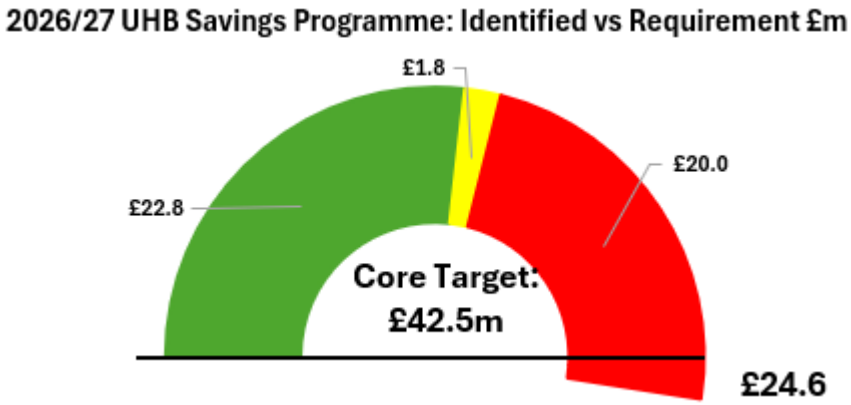
The UHB acknowledges the following Welsh Government expectations:

- The elimination of risks associated with the non-delivery of savings plans by Month 3.
- A significant reduction in the Month 2 assessed risk value of £17.6m, with any residual at-risk savings representing no more than 25% of the remaining savings gap by Month 3.

At Month 5, the UHB is reporting a combined risk of £5.8m in respect of Mitigations yet to be finalised.

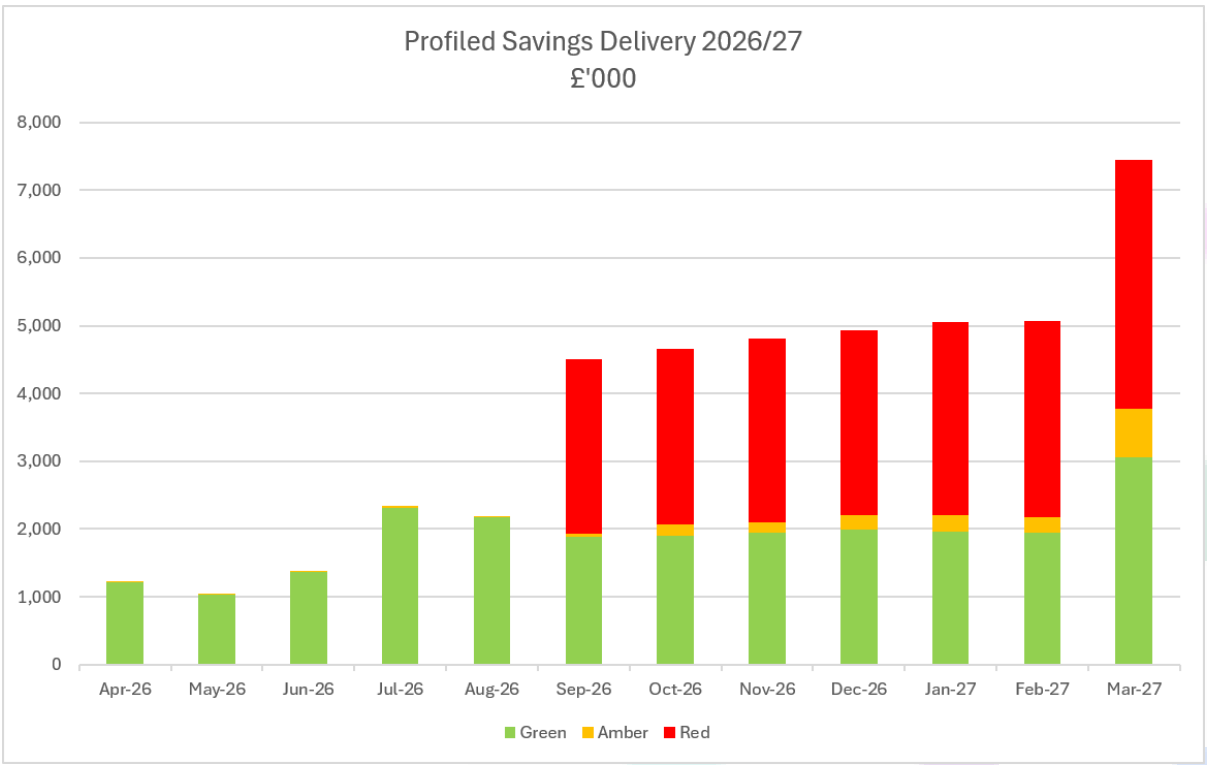
Graph 1 below outlines progress in the identification of Savings Schemes against the Health Board's core savings target.

Graph 1 – Progress in the Identification of Savings Schemes against the core savings target



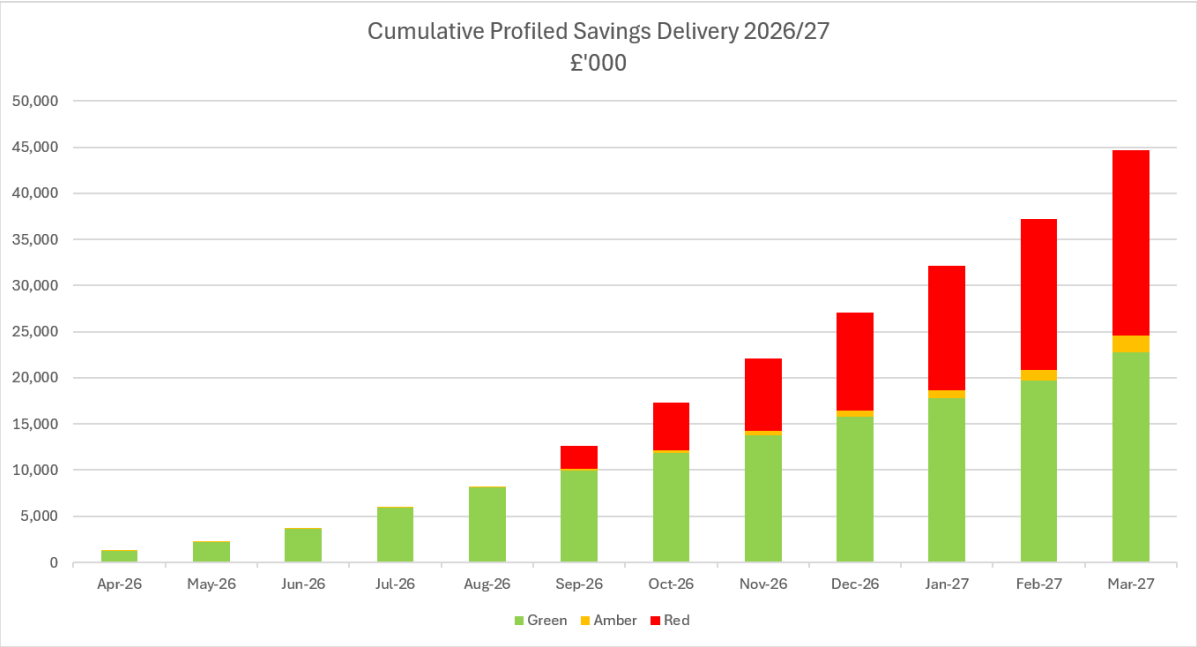
Graph 2 below provides a breakdown of the profiled savings delivery including red schemes against the core UHB savings target of £42.5m.

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 31st August 2026, was £1,486.4m with a further £62.5m of assumed allocations as detailed at Table 5:

Table 5 – Unconfirmed in year Resource Limit Allocations anticipated on 31st August 2026

Unconfirmed Drawing and Resource Limit Allocations as of 31st August 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 Transformation Fund Optometry Community Pathways	0.1
Prevention And Early Years	0.8
Public Health LHBs in Prevention for Gambling Harms	0.0
TSW Funding	0.2
Vertex (JCC)	5.2
VSM Pay Award	0.1
Welsh Risk Pool	(27.2)
Womens Health Hubs	0.2
Total Anticipated Funding £'000s	**62.5**

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 increase in the carrying value of Trade and Other receivables is predominately due to an increase in the value of the WRP debtor.

The increase in the carrying value of Trade and Other Payables is predominately due to an increase in Accruals & Other Payables due to the timing of payments and an increase in the Clinical Negligence provision.

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 August was £6.5m.

In due course, the UHB expects to seek Finance Committee and Board approval to request £86.5m 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 August was 96.4%.

14. CAPITAL RESOURCE LIMIT, IN YEAR SCHEMES & DISPOSALS (TABLES I, J, K, P)

Of the UHB's approved Capital Resource Limit, 8% has been expended to date. All projects are currently forecast to deliver in line with the CRL dated 3 September 2026, totalling £46.760m, with the exception of the ICRF scheme for the Park View Health and Wellbeing Hub.

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.

15. AGED WELSH NHS DEBTORS (TABLE L)

On the 31st August 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.

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.

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 UHB submitted a financial plan at the end of March 2026 which included a forecast deficit of £86.5m. The Health Board submitted a letter to Welsh Government on the 29th of May 2026 confirming its intention to de-risk the financial plan by the end of Quarter 2.

The reported month 5 position is £7.1m above the submitted plan primarily due to the shortfall in the identification and the delivery of savings.

In summary

- There is an urgent need to de-risk the plan.
- The reported year to date position is an overspend of £43.1m with a forecast deficit of £86.5m.
- At month 5 there is adverse variance against plan of £7.1m, as a result of the £9.6m savings deficit and an operational surplus against plan of (£2.5m).
- There are schemes identified to deliver the core savings target of £42.5m. £24.6m of the schemes are categorised as green and an amber, however, there is a significant associated delivery risk linked to £20.0m 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.





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DAVID FLUCK
EXECUTIVE MEDICAL DIRECTOR
(ACTING DEPUTY CHIEF EXECUTIVE)

11th September 2026

ANDREW GOUGH
DEPUTY DIRECTOR OF FINANCE

11th September 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)	Assume recovery of position
Specialist private patient activity reductions											0	
Ongoing high Wet AMD activity and income				(375)							(375)	
Vacancies and other net pay underspends			(4,290)								(4,290)	
Continuing Healthcare demand											0	
Resident Doctors Contract											0	
LHB Expenditure Reduction & JCC Commissioner						(554)					(554)	
Medicines Management (Primary Care & NICE)		(875)									(875)	
Total Unplanned Spend Reductions	0	(875)	(5,140)	(375)	0	(554)	0	0	0	0	(6,944)	
Unplanned Cost Pressures (b/d required in narrative) (Positive Value)												
Medicine Endoscopy Insourcing				979							979	
Medicine Endoscopy Insourcing											0	
Mental Health OOA Placements								1,135			1,135	
Specialist Medical Locum Usage			1,200								1,200	
Specialist private patient activity reductions				584							584	
Ongoing high Wet AMD activity and income				375							375	Netting off previously reported spend reduction
Vacancies and other net pay underspends											0	
Continuing Healthcare demand											0	
Resident Doctors Contract			154								154	
LHB Expenditure Reduction & JCC Commissioner											0	
Medicines Management (Primary Care & NICE)											0	
Total Unplanned Cost Pressures	0	0	1,354	1,938	0	0	0	0	1,135	0	4,427	
Table B2 Total Unplanned Spend Reductions/Cost Pressures												
Medicine Endoscopy Insourcing	0	0	0	979	0	0	0	0	0	0	979	
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	1,135	0	1,135	
Specialist Medical Locum Usage	0	0	350	0	0	0	0	0	0	0	350	
Specialist private patient activity reductions	0	0	0	584	0	0	0	0	0	0	584	
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	(4,290)	0	0	0	0	0	0	0	(4,290)	
Continuing Healthcare demand	0	0	0	0	0	0	0	0	0	0	0	
Resident Doctors Contract	0	0	154	0	0	0	0	0	0	0	154	
LHB Expenditure Reduction & JCC Commissioner	0	0	0	0	0	(554)	0	0	0	0	(554)	
Medicines Management (Primary Care & NICE)	0	(875)	0	0	0	0	0	0	0	0	(875)	
Grand Total	0	(875)	(3,786)	1,563	0	(554)	0	0	1,135	0	(2,517)	
Adjustment for Overachievement of Savings Target											0	
Total Pulling Through to Table A	0	(875)	(3,786)	1,563	0	(554)	0	0	1,135	0	(2,517)	

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			(9,336)								**(9,336)**	
Continuing Healthcare demand											**0**	
Resident Doctors Contract											**0**	
LHB Expenditure Reduction & JCCCommissioner						(1,400)					**(1,400)**	
Medicines Management (Primary Care & NICE)		(2,782)									**(2,782)**	
Total Unplanned Spend Reductions	**0**	**(2,782)**	**(9,696)**	**(375)**	**0**	**(1,400)**	**0**	**0**	**0**	**0**	**(14,253)**	
Unplanned Cost Pressures (b/d required in narrative) (Positive Value)												
Medicine Endoscopy Insourcing				1,154							**1,154**	
Medicine Endoscopy Insourcing			204								**204**	
Mental Health OOA Placements									2,179		**2,179**	
Specialist Medical Locum Usage			1,200								**1,200**	
Ongoing high Wet AMD activity and income				375							**375**	
Specialist private patient activity reductions				701							**701**	
Vacancies and other net pay underspends											**0**	
Continuing Healthcare demand											**0**	
Resident Doctors Contract			1,233								**1,233**	
LHB Expenditure Reduction & JCCCommissioner											**0**	
Medicines Management (Primary Care & NICE)											**0**	
Total Unplanned Cost Pressures	**0**	**0**	**2,637**	**2,230**	**0**	**0**	**0**	**0**	**2,179**	**0**	**7,046**	
Table B2 Total Unplanned Spend Reductions/Cost Pressures												
Medicine Endoscopy Insourcing	0	0	0	1,154	0	0	0	0	0	0	**1,154**	
Medicine Endoscopy Insourcing	0	0	204	0	0	0	0	0	0	0	**204**	
Mental Health OOA Placements	0	0	0	0	0	0	0	0	2,179	0	**2,179**	
Specialist Medical Locum Usage	0	0	840	0	0	0	0	0	0	0	**840**	
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	701	0	0	0	0	0	0	**701**	
Vacancies and other net pay underspends	0	0	(9,336)	0	0	0	0	0	0	0	**(9,336)**	
Continuing Healthcare demand	0	0	0	0	0	0	0	0	0	0	**0**	
Resident Doctors Contract	0	0	1,233	0	0	0	0	0	0	0	**1,233**	
LHB Expenditure Reduction & JCCCommissioner	0	0	0	0	0	(1,400)	0	0	0	0	**(1,400)**	
Medicines Management (Primary Care & NICE)	0	(2,782)	0	0	0	0	0	0	0	0	**(2,782)**	
Grand Total	**0**	**(2,782)**	**(7,059)**	**1,855**	**0**	**(1,400)**	**0**	**0**	**2,179**	**0**	**(7,207)**	
Adjustment for Overachievement of Savings Target											**0**	
Total Pulling Through to Table A	**0**	**(2,782)**	**(7,059)**	**1,855**	**0**	**(1,400)**	**0**	**0**	**2,179**	**0**	**(7,207)**	

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Table A - Movement of Opening Financial Plan to Forecast Outturn

This Table is currently showing 0 errors

Line 12 should reflect the corresponding amounts included within the latest IMTP/AOP submission to WG
Lines 1 - 12 should not be adjusted after Month 1

		In Year Effect	Non Recurring	Recurring	FYE of Recurring		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	In Year Effect
		£'000	£'000	£'000	£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'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	-28,650	-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	-31,746	-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	5,825	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	792	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	399	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	4,770	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	284	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	12,264	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**	**-36,061**	**-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	-12,264	-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	644	470	174	274	15	0	19	19	48	111	44	64	64	64	64	64	83	197	644
16	Other Movement in Month 1 Planned Savings - (Underachievement) / Overachievement	-609	-74	-535	613	16	-32	-30	89	-73	-72	-73	-73	-73	-68	-68	-68	-68	-118	-609
17	Additional In Year Identified Savings - Forecast	11,511	3,226	8,285	10,040	17	0	100	369	1,242	1,326	893	1,104	1,127	1,187	1,212	1,185	1,766	3,037	11,511
18	Variance to Planned RRL	-4	-4			18	55	97	1,018	565	-43	219	-152	-176	-241	-266	-243	-839	1,693	-4
19	Additional In Year & Movement in Planned Welsh Government Funding & Other Income (Positive Value - additional)	-5,087	0	-5,087	-5,087	19			-1,272	-424	-424	-424	-424	-424	-424	-424	-424	-424	-2,120	-5,087
20	In Year Accountancy Gains	0	0	0	0	20	0	0	0	0	0	0	0	0	0	0	0	0	0	0
21	Unplanned Spend Reductions	14,253	14,253	0	0	21	391	892	2,361	1,390	1,910	1,044	1,044	1,044	1,044	1,044	1,044	1,044	6,944	14,253
22	Unplanned Cost Pressures	-7,046	-7,046	0	0	22	-145	-814	-1,196	-1,552	-720	-495	-355	-354	-355	-355	-351	-355	-4,427	-7,046
23	Planned Mitigations Yet To Be Finalised	10,686	0	10,686	23,178	23	0	0	0	0	0	1,527	1,527	1,527	1,527	1,527	1,527	1,527	0	10,686
24	Unplanned Additional Required Mitigations Yet To Be Finalised	5,087	0	5,087	5,087	24	0	0	0	0	0	727	727	727	727	727	727	727	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)**	**-86,547**	**15,538**	**-102,085**	**-86,546**	35	**-9,396**	**-9,401**	**-8,276**	**-8,469**	**-7,577**	**-6,204**	**-6,204**	**-6,204**	**-6,204**	**-6,204**	**-6,204**	**-6,204**	**-43,118**	**-86,547**

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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	(683)	Medium
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**	(6,862)	
	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**	(86,547)	
37	**Worst Case Outturn Scenario**	(93,409)	

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Table C - Identified Expenditure Savings Schemes (Excludes Income Generation & Accountancy Gains)

This Table is currently showing 0 errors

			1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %age of YTD*	Green	Amber	non recurring	recurring	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	Pay	Budget/Plan	179	165	124	143	143	141	123	123	123	123	123	123	755	1,634		1,434	200			
2		Actual/F'cast	179	218	412	650	666	414	427	462	512	515	515	515	2,125	5,484	38.75%	5,093	391	1,710	3,775	4,757
3		Variance	0	53	288	507	523	273	303	338	389	392	392	392	1,371	3,850	*181.59%*	3,659	191			
4	Non-Pay	Budget/Plan	512	357	419	395	395	406	326	326	337	326	326	1,312	2,078	5,435		4,820	615			
5		Actual/F'cast	454	328	413	531	507	506	565	565	588	597	577	2,137	2,232	7,768	28.74%	6,417	1,351	4,337	3,430	3,849
6		Variance	(58)	(29)	(6)	136	111	100	239	239	252	272	252	826	154	2,333	*7.41%*	1,597	736			
7	Primary Care - Drugs & Appliances	Budget/Plan	97	97	97	100	100	101	101	101	101	101	101	101	489	1,195		1,195	0			
8		Actual/F'cast	122	124	123	126	126	126	181	181	181	183	183	183	620	1,839	33.73%	1,832	7	0	1,839	2,192
9		Variance	25	28	26	26	26	25	80	80	80	82	82	82	131	644	*26.85%*	637	7			
10	Secondary Care Drugs	Budget/Plan	163	178	203	198	213	268	278	288	313	298	298	313	955	3,014		3,014	0			
11		Actual/F'cast	164	196	294	458	660	546	527	527	552	537	537	552	1,773	5,550	31.94%	5,550	0	1,189	4,362	5,584
12		Variance	1	18	91	260	447	277	249	239	239	239	239	239	817	2,537	*85.55%*	2,537	0			
13	CHC/FNC	Budget/Plan	82	82	82	124	124	124	124	124	124	124	124	124	493	1,359		1,259	100			
14		Actual/F'cast	82	82	142	342	248	245	248	245	248	248	241	248	896	2,618	34.21%	2,477	141	0	2,618	2,688
15		Variance	0	0	60	218	124	122	124	122	124	124	117	124	402	1,259	*81.52%*	1,218	41			
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	44	200	22.22%	200	0	200	0	0
27		Variance	0	0	0	22	22	22	22	22	22	22	22	22	44	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	4,770	12,637		11,722	0			
35		Actual/F'cast	1,001	948	1,383	2,129	2,229	1,859	1,982	2,015	2,117	2,116	2,089	3,671	7,690	23,539		21,650	1,889	7,516	16,023	19,070
36		Variance	(32)	70	459	1,169	1,254	819	1,031	1,054	1,119	1,144	1,117	1,698	2,920	10,902		9,928	1,889			
37	Variance in month		(3.12%)	7.99%	49.64%	121.79%	128.58%	78.81%	108.32%	109.56%	112.18%	117.74%	114.98%	86.08%	61.20%							
38	In month achievement against FY forecast		4.25%	4.03%	5.87%	9.05%	9.47%	7.90%	8.42%	8.56%	8.99%	8.99%	8.87%	15.59%								

Cardiff & Vale ULHB

Period : Aug 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	710	1,434	1,434	0			
2	Pay - General & Substantive	Actual/F'cast	179	218	406	608	586	322	335	334	384	387	387	387	1,998	4,535	4,194	341	1,630	2,905	3,458
3		Variance	0	53	282	487	465	204	234	233	284	286	286	286	1,287	3,101	2,760	341			
4		Budget/Plan	0	0	0	22	22	22	22	22	22	22	22	22	44	200	0	200			
5	Pay - Variable	Actual/F'cast	0	0	5	42	80	91	91	128	128	128	128	128	128	950	900	50	80	870	1,299
6		Variance	0	0	5	20	58	69	69	106	106	106	106	106	83	750	900	(150)			
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	755	1,634	1,434	200			
11	Total	Actual/F'cast	179	218	412	650	666	414	427	462	512	515	515	515	2,125	5,484	5,093	391	1,710	3,775	4,757
12		Variance	0	53	288	507	523	273	303	338	389	392	392	392	1,371	3,850	3,659	191			

Cardiff & Vale ULHB

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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	4,770	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	4,653	12,028	4,290	7,738	1,291	9,029
	Variance	(32)	(30)	89	(73)	(72)	(73)	(73)	(73)	(68)	(68)	(68)	(68)	(118)	(609)	(74)	(535)	1,148	613
	In Year - Plan	5	95	341	987	1,129	826	820	1,282	1,324	1,354	1,352	2,108	2,557	11,625	3,028	8,597	(2,145)	6,452
	In Year - Actual/Forecast	0	100	369	1,242	1,326	893	1,104	1,127	1,187	1,212	1,185	1,766	3,037	11,511	3,226	8,285	1,756	10,040
	Variance	(5)	5	28	256	196	66	284	(155)	(137)	(142)	(167)	(342)	480	(114)	198	(312)	3,901	3,589
	Total Plan	1,038	973	1,265	1,947	2,105	1,866	1,772	2,244	2,322	2,325	2,324	4,081	7,328	24,262	7,392	16,870	(2,002)	14,868
	Total Actual/Forecast	1,001	948	1,383	2,129	2,229	1,859	1,982	2,015	2,117	2,116	2,089	3,671	7,690	23,539	7,516	16,023	3,047	19,070
	Total Variance	(38)	(24)	117	183	124	(7)	210	(229)	(205)	(210)	(235)	(410)	362	(723)	124	(847)	5,049	4,202
Net Income Generation	Month 1 - Plan	172	26	31	31	24	24	24	24	24	24	24	24	284	450	350	100	(100)	0
	Month 1 - Actual/Forecast	172	26	31	57	24	24	24	24	24	24	24	24	310	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	44	64	64	64	64	64	83	172	618	439	179	(139)	40
	In Year - Actual/Forecast	0	19	19	22	111	44	64	64	64	64	64	83	171	618	444	174	0	174
	Variance	0	0	0	(8)	7	0	0	0	0	0	0	0	(1)	(1)	4	(5)	139	134
	Total Plan	172	45	50	60	128	68	88	88	88	88	88	107	455	1,068	789	279	(239)	40
	Total Actual/Forecast	172	45	50	79	135	68	88	88	88	88	88	107	481	1,093	819	274	0	274
	Total Variance	0	0	0	18	7	0	0	0	0	0	0	0	25	25	30	(5)	239	234
Accountancy Gains	In Year - Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Actual/Forecast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	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	5,054	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	4,962	12,504	4,665	7,838	1,291	9,129
	Variance	(32)	(30)	89	(47)	(72)	(73)	(73)	(73)	(68)	(68)	(68)	(68)	(92)	(583)	(48)	(535)	1,248	713
	In Year - Plan	5	113	360	1,016	1,234	870	884	1,346	1,388	1,418	1,416	2,191	2,729	12,243	3,468	8,776	(2,284)	6,492
	In Year - Actual/Forecast	0	118	389	1,264	1,437	937	1,168	1,191	1,251	1,276	1,249	1,849	3,208	12,128	3,670	8,459	1,756	10,215
	Variance	(5)	5	28	248	203	66	284	(155)	(137)	(142)	(167)	(342)	479	(115)	202	(317)	4,040	3,723
	Total Plan	1,210	1,018	1,315	2,007	2,233	1,934	1,860	2,332	2,410	2,413	2,412	4,188	7,783	25,330	8,181	17,149	(2,242)	14,908
	Total Actual/Forecast	1,173	993	1,433	2,208	2,364	1,927	2,070	2,103	2,204	2,203	2,177	3,777	8,171	24,632	8,335	16,297	3,047	19,344
	Total Variance	(38)	(24)	117	201	131	(7)	210	(229)	(205)	(210)	(235)	(410)	388	(698)	154	(852)	5,288	4,436

Summary of Forecast Month 1 & In Year (£000's) - Green & Amber	Cash-Releasing Saving (Pay)	Cash-Releasing Saving (Non Pay)	Cost Avoidance	Savings Total	Income Generation	Accountancy Gains
All Service Areas	2,975	2,183	0	**5,158**	488	0
Scheduled Care	1,564	9,307	0	**10,871**	466	0
Unscheduled Care	33	0	0	**33**	0	0
Mental Health	177	544	0	**721**	0	0
Community Services	54	834	0	**888**	0	0
Primary Care	20	1,974	0	**1,994**	0	0
Commissioned Services - CHC	0	2,473	0	**2,473**	0	0
Commissioned Services - Specialised Services	0	0	0	**0**	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	**5,456**	**18,054**	**0**	**23,510**	**1,074**	**0**

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	Risk of Under Delivery (Amber Schemes only)	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		18		Month 1		01-Apr-26	Green
2	Cardiff & Vale ULHB	O&G - Annual Leave Purchase	Children and Women	O&G	NR	Cash-Releasing Saving	16		22		Month 1		01-Apr-26	Green
3	Cardiff & Vale ULHB	CYPFHS - Annual Leave Purchase	Children and Women	CYPFHS	NR	Cash-Releasing Saving	42		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		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		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		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		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		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		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		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		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		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		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		200		Month 1		01-Apr-26	Green

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31	Cardiff & Vale ULHB	R&D parkinsos AskBio Trial x 5 patients	Clinical Diagnostics and Therapeutics	RADIOLOGY	NR	Income Generation	135		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		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		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		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		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		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

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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		650		Month 1		01-Apr-26	Green
77	Cardiff & Vale ULHB	Haem Drug rebates	Specialist Services	HIMM	NR	Cash-Releasing Saving	220		220		Month 1		01-Apr-26	Green
78	Cardiff & Vale ULHB	Advanced Therapy Neuro trial	Specialist Services	Neurosciences	NR	Cash-Releasing Saving	100		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		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

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91	Cardiff & Vale ULHB	Additional device discount	Specialist Services	Cardiothoracic	NR	Cash-Releasing Saving	160		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		130		Month 1	130	01-Apr-26	Green
95	Cardiff & Vale ULHB	Review Endocrine Service Pathway	Surgery	General Surgery	NR	Cash-Releasing Saving	132		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		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		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		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		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		216		Month 1		01-Apr-26	Green
112	Cardiff & Vale ULHB	Cochlear purchase discounts and free processors	Surgery	Audiology	NR	Cash-Releasing Saving	56		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		13		Month 1		01-Apr-26	Green
114	Cardiff & Vale ULHB	Recovery of Prior Approval & IPFR Income	Surgery	General Surgery	R	Income Generation	100		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		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		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		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		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		12		In Year	0	01-May-26	Green

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121	Cardiff & Vale ULHB	Release of HPLC 1260 Service	Clinical Diagnostics and Therapeutics	MBI	NR	Cash-Releasing Saving	6		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		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		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		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		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		8		In Year	15	01-Sep-26	Green
127	Cardiff & Vale ULHB	Robot cleaning	Capital Estates and Facilities	Housekeeping	R	Cash-Releasing Saving	25		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		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		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		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		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		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		141		In Year	140.94	01-Jul-26	Amber
134	Cardiff & Vale ULHB	Lived Experience / Peer Support Reshaping	Mental Health	Clinical Board Management	R	Cash-Releasing Saving	32		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		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		5		In Year	0	01-Jun-26	Green
137	Cardiff & Vale ULHB	Private Patient Income	Surgery	T&O	R	Income Generation	5		0		In Year		01-Jul-26	Amber
138	Cardiff & Vale ULHB	Private Patient Income	Surgery	Urology	R	Income Generation	50		50		In Year	50	01-May-26	Green
139	Cardiff & Vale ULHB	TACU closure	Surgery	T&O	NR	Cash-Releasing Saving	40		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		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		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		15		In Year	18	01-Jun-26	Green
143	Cardiff & Vale ULHB	SAP Patients IPFR Income	Surgery	General Surgery	R	Income Generation	55		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	438		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		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		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

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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		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		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	Amber
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	Amber
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	Amber
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

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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	600		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		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		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		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	Amber
195	Cardiff & Vale ULHB	TACU closure	Surgery	T&O	NR	Cash-Releasing Saving	20		20		In Year		01-Jul-26	Green
196	Cardiff & Vale ULHB	Admin & Clerical Band 6 Vacancy	Surgery	Urology	NR	Cash-Releasing Saving	13		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		8		In Year		01-May-26	Green
198	Cardiff & Vale ULHB	CTM IR SLA Income	Surgery	General Surgery	NR	Income Generation	83		87		In Year		01-Jun-26	Green
199	Cardiff & Vale ULHB	Temp closure of 9 beds on B6 (6 months extension)	Surgery	ENT	NR	Cash-Releasing Saving	88		105		In Year		01-Oct-26	Green
200	Cardiff & Vale ULHB	IVT Patent Expiry	Surgery	Ophthalmology	NR	Cash-Releasing Saving	650		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		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		50		In Year	50	01-Jun-26	Amber
203	Cardiff & Vale ULHB	Review uncoded activity	Children and Women	CHFW	R	Cash-Releasing Saving	100		100		In Year	100	01-Sep-26	Amber
204	Cardiff & Vale ULHB	CHFW - Student Streamliner Variable Pay Reduction	Children and Women	CHFW	R	Cash-Releasing Saving	182		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		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		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		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		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		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		1,200		In Year	1205	01-Jul-26	Green

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211	Cardiff & Vale ULHB	Efficiencies from change temporary Acute model	Medicine	All Areas	NR	Cash-Releasing Saving	239		239		In Year	0	01-Oct-26	Amber
212	Cardiff & Vale ULHB	CHC uplift plan	Mental Health	Continuing Healthcare	R	Cash-Releasing Saving	45		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		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		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		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		64		In Year	81	01-Aug-26	Green
217	Cardiff & Vale ULHB	Review MS prescribing pathways	Specialist Services	Corporate	R	Cash-Releasing Saving	60		60		In Year	80	01-Aug-26	Green
218	Cardiff & Vale ULHB	Alternative Vascath supplier	Specialist Services	Critical care	R	Cash-Releasing Saving	9		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		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		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		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		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		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		180		In Year		01-Jul-26	Green
225	Cardiff & Vale ULHB	Cessation of plastics clinic	Specialist Services	MTC	R	Cash-Releasing Saving	13		13		In Year	25	01-Oct-26	Green
226	Cardiff & Vale ULHB	Eculizumab price reduction	Specialist Services	N&T	R	Cash-Releasing Saving	127		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		235		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		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		475		In Year		01-Sep-26	Amber
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

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240	Cardiff & Vale ULHB	EP Framework - J&J	Specialist Services	Cardiothoracic	NR	Cash-Releasing Saving	7		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		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		9		In Year		01-Aug-26	Green
246	Cardiff & Vale ULHB	SLT ACTIONS - VACANCY HOLD	Surgery	Dental	NR	Cash-Releasing Saving	23		23		In Year		01-Aug-26	Green
247	Cardiff & Vale ULHB	SLT ACTIONS - VACANCY HOLD	Surgery	ENT	NR	Cash-Releasing Saving	2		2		In Year		01-Aug-26	Green
248	Cardiff & Vale ULHB	SLT ACTIONS - VACANCY HOLD	Surgery	General Surgery	NR	Cash-Releasing Saving	3		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		6		In Year		01-Aug-26	Green