Minutes of the Public Finance & Performance Committee Meeting
22nd July 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
Ceri Phillips	CP	CAV UHB Vice Chair
Clive Curtis	CC	Independent Member - Community
David Edwards	DE	Independent Member – Digital
In Attendance:		
Catherine Phillips	CPH	Executive Director of Finance
Paul Bostock	PB	Chief Operating Officer
Matt Phillips	MP	Director of Corporate Governance
Andrew Gough	AG	Deputy Director of Finance (Strategic)
Suzanne Rankin	SR	Chief Executive Officer
Victoria LeGrys	VL	Deputy Director of Strategic Planning
Chris Markall	CM	Assistant Director of Finance
Natasha Goswell	NG	Deputy Director of Nursing
Ruth Jordan	RJ	Assistant Director of Improvement & Implementation
Sarah Martin	SM	Research & Development Manager
Secretariat:		
Nikki Regan	NR	Corporate Governance Officer
Apologies:		
Adam Roberts	AR	Executive Director of Strategic Planning
Judi Rhys	JR	Independent Member – Third Sector
Rachna Upadhya	RU	Independent Member – General
Steve Riley	SR	Independent Member – University
Susan Lloyd-Selby	SLS	Independent Member – Local Authority

Ref:	Agenda Item:	Action
FPC 22.07/1.1	**Welcome, Introductions & Apologies** Rhian Thomas – Committee Chair (CC) welcomed everybody to the meeting in English and in Welsh.	
FPC 22.07/1.2	**Declarations of Interest** No declarations of interest were raised.	
FPC 22.07/1.3	**Minutes of the Finance and Performance Meeting held on 17th June 2026** The minutes of the meeting held on 17th June 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	**Actions following the Finance & Performance Meeting on 17th June 2026**	

22.07/1.4	The action log was discussed and noted. **The Finance and Performance Committee resolved that:** a) The Action Log for the Finance and Performance Committee was noted.	
FPC 22.07/1.5	**Chairs Action since previous meeting** There were no Chair's Actions taken since the last meeting	
FPC 22.07/2.1	**Financial Report – Month 3 Position (including savings tracker)** David Edwards – Independent Member Digital (IMD) flagged discrepancies in the figures on page 6 and page 12 of the month 3 report, specifically noting a mismatch between the narrative and table values for the overspend and savings target. Andrew Gough – Deputy Director of Finance (DDF) confirmed both were typos, clarified the correct figures and would correct them for the next meeting. The DDF highlighted the following points regarding the Financial Report: • The reported position does not provide assurance of delivering the planned £86.5m deficit; operational surplus is offset by a shortfall in savings delivery. • The main issue is the lack of a complete, recurrent savings programme; pace of decision-making and implementation must increase to de-risk the plan by end of quarter two. • The savings target increased from £42.5m to £47.6m due to JCC arbitration, raising delivery risk. • At month 3, a deficit of £27.7m was reported, with a £6.9m shortfall in planned savings and a £1.5m operational surplus, resulting in a £5.4m adverse variance against plan. • Operational surplus is mainly due to vacancies and underspends, which are not recurring benefits and should not distract from the savings gap. • Operational pressures include medical endoscopy, mental health out-of-area placements, specialist medical locum costs, continuing healthcare growth, and reduced private patient income. • Non-recurrent benefits offsetting recurrent issues will worsen the underlying deficit in future years; focus must be on addressing recurrent issues. • Workforce data shows a reduction in substantive whole-time equivalents, but recent increases in clinical and admin staff; vacancy-related underspends are not assured without controls and service plans. • Non-pay expenditure increased by 5.8% year-on-year, driven by continuing healthcare, mental health placements, commissioned services, premises, digital costs, and contractual uplifts. • Only £19.9m of green/amber savings schemes identified (41.8% of target); recurrent savings gap is £31.9m, requiring additional decisions and interventions. • Internal turnaround meetings have improved scrutiny but need clearer parameters and targets to translate opportunities into delivery actions. • Forecasting from month 3 shows a £21.6m risk to delivery against the £86.5m plan; underlying deficit could reach £120m if recurrent savings gap is not closed. • Capital programme expected to deliver within the year; no material capital issues requiring escalation. The CC noted the extra £5m financial burden was difficult for CAVUHB and questioned the logic from JCC, which was based on achieving cost efficiencies. She highlighted that while requesting 2% efficiency (i.e., £5m) was straightforward, providing actual solutions and ideas for achieving it is much harder. She recalled there was supposed to be guidance accompanying the request and asked about tangible suggestions for achieving the efficiency savings. The DDF confirmed the target was received late in the planning process and was a target, not a plan. He stated the arbitration response requires continued partnership work with JCC	

	to develop a plan moving forward. He acknowledged disappointment that the target was not accompanied by a plan, so there was no firm foundation yet. He indicated the responsibility now sits with all chief execs in the JCC to support the process. Suzanne Rankin – Chief Executive (CEO) confirmed the CC's recollection was correct and explained that the lack of confidence in the partnership proposal to de-risk the efficiency requirement was a key issue in the arbitration outcome. She noted there was a new Chief Commissioner at the Joint Committee, whom she and Catherine have met with twice, and there is recognition that the JCC team has work to do in this area. She stated she is not comfortable that the £5m ask will be achieved, even though the new Chief Commissioner is committed to partnership working. She observed that other health boards are relatively comfortable with the scenario because much of the JCC gap has been mitigated by passing the efficiency requirement to the two main providers (Cardiff & Vale and Swansea), which de-risks it for the commissioners. Both providers have challenged this, but the remaining gap is now a commissioner risk, of which Cardiff & Vale would also get a share. She said this situation clearly articulates the challenge with the current arrangement and puts additional demand on an already challenged scenario. The VC asked whether the significant differential in the price JCC gives for services compared to what English providers charge Betsi Cadwaladr UHB featured as part of the administration discussions. The CEO noted that the funding differential featured in the overall discussion, but not particularly in the arbitration discussion. She mentioned there are data clarifications to be sought regarding the extent of care (secondary vs. tertiary) and that they are trying to understand the actual baseline position. The EDF noted there are several different issues at play, including the 2% efficiency passed on in tariff through specialist commissioning, which is why it's applied in the Welsh context. She emphasised the need to consider whether the tariff is appropriate for the Welsh population, given differences in critical mass compared to the English model. She questioned whether they provide the critical mass needed for the population and highlighted that some services are specialist in England but only secondary in Wales, making the analysis complex. She stated that some services are provided with no tariff, while others have a tariff based on previous business cases, and this needs to be worked through. The IMD stated he wouldn't want anyone to think that by saying "remain credible," people might believe they aren't really concerned about the issues, emphasising that everyone is indeed very concerned. Paul Bostock – Chief Operating Officer (COO) noted that for Q1, recruitment is tracking at a flat rate, with no big increases in headcount. He warned that for Q2 onwards, there is a backlog of patient and staff recruitment that has been delayed or paused, and decisive action is needed now to prevent a surge in appointments. He said CAVUHB will discuss tightening vacancy controls at the senior leadership team meeting, acknowledging that previous vacancy freezes were tough but necessary. He stressed that if action isn't taken, there could be hundreds of appointments made in the next few months, which is not planned or funded, and this doesn't account for people who will leave. The CC stated the committee does not want to reconvene monthly only to note that they are still far from de-risking the savings profile. She asked what specific activities, tasks, or missions are planned from now until the next Finance Committee meeting in September to de-risk the savings gap, seeking assurance on progress and understanding of the challenge. The CEO responded that the committee needs confidence in delivery actions and impact, and that turnaround actions and missions are underway, focusing on avoiding cost pressures, controlling expenditure, and using resources more efficiently. Clear accountability and delivery timelines are being established, with a trajectory plan similar to "turn the curve" being developed.	

	The EDF added that the internal turnaround process identifies issues, with focus on four clinical boards. Actions are being translated into savings and operational plans, and for boards not delivering, organisational interventions will be considered. A trajectory to close the gap by end of quarter three is needed, and any remaining gap in four weeks will be a serious problem. The VC shared they had conversations with various people in the organisation, noting that length of stay is a major factor in excess bed days. He suggested that, within medicine, commissioning services outside the hospital would be more efficient than admitting patients unnecessarily, and this could be done relatively speedily. He emphasised the need to change the mindset from managing budgets within clinical boards to managing budgets overall, aiming for improved quality of care and best value for residents. The EDF noted there are a few examples, particularly in mental health, where facilities could provide services differently through the volunteer sector, highlighting work started this year but needing more development. She emphasised the importance of understanding what the population needs and providing services driven from a commissioning point of view, not just provision, linking this to the clinical services plan. She stated that while there are changes in pathway and innovation, they are more incremental, and the length of stay improvement should align with the clinical services plan to transform care delivery, moving more services out of hospital. She explained that turnaround must give security for the in-year and recurrent position, but improvement and transformation activities need to move alongside, ensuring actions taken today support and build towards future goals, not undermine them. **The Finance and Performance Committee resolved that:** a) It was noted the reported year to date position is an overspend of £27.073m with a planning deficit of£86.547m. b) It was noted there is an urgent need to derisk the £86.547m deficit plan. c) It was noted that at Month 03 there is an adverse variance against plan of £5.436m, driven by a £6.925msavings deficit, partially offset by an operational surplus against plan of (£1.489m). d) It was noted there is a gap of £27.703m against the £47.608m in year savings target, with £19.905m(41.81%) of green and amber schemes identified at Month 3. e) It was noted that delivery of the deficit plan is contingent on delivery of a full savings programme and confirmation of all expected income streams. f) It was noted there are £42.401m of outstanding resource limit allocations and that in due course the UHB expects to seek Finance Committee and Board approval to request £86.547m strategic cash support from Welsh Government to support the planned deficit.	
FPC 22.07/2.2	**Operational Performance Update** The COO updated and highlighted the following points on the Operational Performance Update: • June was challenging due to a heat wave, affecting attendances and leading to business continuity declaration; performance dipped, especially around 12-hour waits in EU. • Requested quarter-on-quarter analysis to understand patient types and presentations, especially during the heat wave. • At least 200 operations were cancelled, radiology services ran at half capacity, and a proper debrief is needed to assess the impact. • Emphasised the need to better reflect demand for primary and community services, noting 18k district nurse visits last month, more than EU attendances. • Physical health pathway delays increased in number but average delay days decreased, resulting in a reduction of over 1,200 bed days compared to last June; mental health delays decreased in number but average length of stay increased. 4 • Cancer performance remained stable with a 20% increase in demand; NHS P&I requested more information on the cancer plan.	

- Regional plan for 104-week waits submitted; complex spinal surgery remains a challenge, with demand and capacity work ongoing.
- Diagnostics saw a jump in eight-week waits due to new radiology reporting system and heat wave impacts; promised clearer update next time.
- Outpatient transformation efforts include mandating overbooking in clinics with high DNA rates, rolling out patient-initiated follow-ups, and focusing on new-to-follow-up ratios.
- Mental health focus on out-of-area placements, improvement work in the clinical board, and challenges in neurodevelopment plans due to non-recurrent funding.

The CC noted there were numerous references to PNI (NHS Performance & Improvement) interactions in the operational performance update and asked Paul about the insights PNI is providing regarding ways of working, processes, and methods.

The COO responded that the relationship with NHS PNI has been supportive, with PNI sending in support around booking processes and providing insights into efficiency, particularly in patient booking. He explained PNI's role has been to understand the health board's story, agree or challenge it, and validate their position. He mentioned PNI has provided some advice, such as demand and capacity methodology and booking methodology, but not a list of direct actions. Much of the challenge is embedded in cultural change.

The CEO agreed, highlighting that much of the challenge is in culture, practice, and securing clinical leadership support, and commended the clinical leadership in out-of-area work.

The COO highlighted the following points on Cancer pathway, GP referrals, ambulance handover and EU flow:

- The cancer pathway conversation has been ongoing since the standards were created; although referrals are up, conversion rates remain consistent, suggesting patients referred are appropriate, but the volume causes longer waits for those with cancer. Advice on pathway management is welcomed, as GPs are encouraged to refer if concerned.
- The challenge is that increased referrals mean more patients to see, leading to longer waits for those who do have cancer.
- For ambulance handover, the target is 95% within 45 minutes; current performance is around 86-87%, with average handover times of 25-30 minutes. Most delays are due to flow issues within EU, not the handover process itself.
- Improving flow and reducing congestion in EU is key to reducing ambulance handover delays and 12-hour waits. The number of patients seen per hour is stark, and holding people to account for throughput is important.
- CAVUHB is consistently good each month compared to other health boards, but needs to achieve the additional 8% performance to meet the target.

VC asked if mental health out-of-area placements are due to capacity and demand, and whether managing demand differently and commissioning services (e.g., tier 0, tier 1 from the third sector) could help. They referenced 36 Degrees' involvement and asked what is being done to address the problem differently.

The COO responded candidly, noting CAVUHB is an outlier with a growing out-of-area problem despite opening extra capacity. He confirmed some additional support was commissioned with Mind and low-level beds to take patients out of acute settings but acknowledged more opportunity may exist. He explained that improvement work is ongoing, including reviewing the process for out-of-area placements and strengthening community mental health teams to reduce inpatient demand. He also mentioned reaching out to Kara Rogers for support, as the situation feels unusual compared to other health boards.

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 22.07/2.3	**Q1 Annual Plan Report** Vicky LeGrys – Deputy Director of Strategic Planning – (DDSP) highlighted the following points on the Q1 annual plan report: • The report provides assurance on delivery of strategic and operational qualitative actions, with RAG ratings based on progress assessed through strategic portfolio boards and operational programmes. • About 50% of actions are rated green, which is expected for this time of year; no actions are significantly off track (none rated red), indicating all programmes are mobilising and governance is being established. • Progress is strong in population health, with that portfolio reporting green, and foundational work is underway for delivery through the rest of the year. • The launch of the Clinical Services Plan, progress in regional planning via the Southeast Wales Regional Joint Committee, and establishment of the Community by Design programme are highlighted as critical for enabling the shift to new care models and integration with partners. • Infrastructure and people portfolios are advancing major digital and workforce initiatives, including the People and Culture Plan and funding for UHW redevelopment, aligning with service level planning. • Operational improvement programmes are progressing, especially in areas aligned to significant risks and priorities like length of stay, theatres, and UEC. • For quarter two, focus will be on strengthening foundational elements, consistency across programmes, service level planning, and developing the People and Culture Plan to align with infrastructure and service plans. • An organisational approach to performance management and integration improvement plan is being developed, with demand and capacity modelling and workforce planning as key items for future updates. The DDSP noted the process is currently labour intensive, relying on portfolio boards to assess progress and summarise well, with planning leads aligned to each portfolio to ensure this happens. She mentioned plans to build infrastructure for more systematic reporting in the future but confirmed no concerns for quarter two reporting. **The Committee resolved that:** a) The progress highlighted in the Q1 annual plan report was noted b) The submission of the Q1 position to Welsh Government was approved.	
FPC 22.07/2.4	**BAF Decarbonisation & Climate** Ruth Jordan – Assistant Director of Improvement & Implementation (ADII) presented and highlighted the following points: • **Targets & Challenges**: Welsh Government's (WG) targets for emissions reduction (16% by 2025, 34% by 2030) and CAVUHB's own targets were even more ambitious. The significant gap between current emissions and required reductions were emphasised, with emissions trending upward due to increased demand and carbon lock-in from infrastructure, especially at UHW, which is the largest public sector emitter in Wales. • **Programme Structure**: The programme operates with three groups: corporate sustainability and decarbonisation, clinical sustainability and decarbonisation, and climate adaptation and resilience. Each group has specific responsibilities, such as localising national plans, embedding sustainability in clinical services, and developing adaptation plans for climate risks like heatwaves and flooding. • **Progress & Actions**: Progress included assigning action owners, submitting required reports, developing the corporate plan, appointing sustainability leads in clinical boards, and submitting the first climate clinical risk assessment to WG. Workshops and surveys were used to inform adaptation planning, especially for heatwaves. • **Risks & Capacity**: Three strategic challenges were highlighted: the emissions gap, adaptation gap (increasing frequency/severity of climate risks), and limited expert	

	capacity/resources. Ongoing efforts were noted to secure grants and build resilience, but current maturity is not sufficient for the expected climate impacts. • **Integration Call**: Climate and sustainability considerations should be integrated upfront in all organisational decision-making, not just measured after the fact. Committee members were encouraged to ask about carbon reduction and adaptation impacts when leading projects. • **Committee Support**: The committee was asked to note progress, risks, and support continued integration of sustainability and climate resilience in planning and performance arrangements. The EDF commended Ruth, Tom Porter, and Arjun for their driving force behind the programme, noting the significant mobilisation and engagement across corporate and clinical boards despite limited resources. She discussed the overlap between delivering clinical care and mobilising the clinical services plan, emphasising that shifting to more prevention and less illness management will have a major impact on emissions. The ADII agreed with the EDF, emphasising that one of the key messages was to consider climate impacts upfront in decision-making for all programmes and projects—not just measure the impact afterwards. She compared this to how quality and air quality are considered when making decisions, stating climate should be treated the same way. She explained they are working to make it easy for people leading projects to integrate climate considerations, given the complexity. She called for everyone involved in any piece of work to ask about its impact on carbon reduction or adaptation, as this would greatly help the programme. **The Committee resolved that:** a) The progress made in delivering the Sustainability and Climate Response Programme was noted. b) The risks associated with the current emissions gap and adaptation gap was noted. c) The continued integration of sustainability and climate resilience considerations within organisational planning and performance arrangements was supported	
FPC 22.07/4.1	**Q4 RPB Performance & Finance Report 2025-26** Chris Markall – Assistant Director of Finance (ADF) presented and highlighted the following points: • Three main elements were noted: final quarter four reports for 2025-26 from the Regional Partnership Board, full utilisation of about £20m funds, and the annual report hyperlink for further details. • WG's positive reception of the reports, but highlighted an ongoing shortfall in the proportion of funds directed to the third sector, which remains a focus for improvement. • The financial plan for 2026-27 was outlined, including a deployment of £20.3m and an overcommitment of £140k, which was expected to be managed through anticipated slippage. • The ongoing risk regarding the future of the Regional Integration Fund, noting the lack of clarity beyond this financial year and the significant risk to partnership and statutory partners, with £7.5m deployed on health board-related services. • Ongoing dialogue with WG was expected to provide more clarity soon, and updates will be brought back to the committee. The COO noted they've been grappling with the spectre of RIF closing for several years, and confirmed the money is flat cash, so its value decreases each year due to inflation. He stated the fund was originally intended for pump priming, but now seems baked into baselines, delivering core services on a non-recurrent flat cash basis. He expressed uncertainty about whether the money is being used as intended, questioning if it is still serving its original purpose. The CAVUHB Chair emphasised the importance of not letting the pause on RIF decisions go on too long, warning against waiting for a last-minute solution and highlighting the risk of carrying financial risk into the new year, especially given the jobs involved. She questioned	

	whether there was evidence from RIF-supported projects that allowed funding to be stepped down in other areas, noting the fund's purpose was to demonstrate better ways of working and enable adjustments to other services. She cautioned against a blanket approach to ending RIF-funded projects, advocating for a review of all activity to prioritise services based on value, not just their funding source. She stressed the need to assess the value of services delivered, suggesting some RIF-funded programmes may be more important than some core-funded ones, and that money should be reallocated based on priority. The ADF explained that while some RIF-funded areas, like the at home programme, have been embedded into core services, many benefits realised are cost avoidance rather than a shift of resources out of RIF. He acknowledged there is an ongoing challenge, as services have become embedded and funded by RIF without being incorporated into core funds, presenting the risks previously highlighted. He stated that, moving forward, they will need to assess RIF-funded services alongside other pilots and programmes in the UHB to make value-based judgments, not just consider RIF-funded projects in isolation. The EDF noted that when working back from decision points, it may already be too late due to the number of people involved. She emphasised the importance of managing the partnership carefully, stating CAVUHB should not go in a different direction from other partners and that a clear organisational view is needed for partnership discussions. She highlighted the need to consider what would have been done without RIF and whether the current pathway offers better value, suggesting the focus should be on the overall value, not just additionality. **The Committee resolved that:** a) The Q4 report for RPB funding in 2025-26 was noted b) The agreed RPB budget allocations for 2026-27 were noted. c) The imminent closure of the Regional Integration Fund, together with the associated risk to the UHB was noted.	
FPC 22.07/4.2	**Haematology Strategic Outline Case** The EDF stated the JACIE inspection did not go well for haematology services, resulting in a warranted outpatient extension and the need to look at an inpatient extension as a significant priority. She explained there was an action plan sent to JACIE and a bid to JCC for revenue, both previously seen by F&P, and this is the final part of the response. She described this as a bid to WG for £90-£95m to establish a sustainable inpatient solution at UHW for haematology provision, addressing JACIE accreditation issues. She confirmed this will go to Board next week, with revenue implications expected to be met by JCC after scrutiny. **The Committee resolved that:** a) The content of the paper was noted. b) The Strategic Outline Case as included in Appendix 1, for the provision of a new inpatient facility to deliver Haematolgy services including BMT and CAR-T in line with the JACIE standards was endorsed c) It was recommended that the Board approve the SOC for formal submission to Welsh Government to seek capital investment and approval to progress a combined OBC/FBC	
FPC 22.07/4.3	**New R&D Income Management Policy** Sarah Martin – The Research & Development Manager (RDM) highlighted the following points on the R&D income management policy: • The new R&D income management policy aims to standardise research income processes across CAVUHB overview for strategic embedding. • The policy aligns with WG guidance and highlighted four main changes: central R&D accountant oversight, creation of a capacity/building fund to ring-fence research money, aligning income distribution to the standard costing template	

	(increasing health board overheads), and consolidating PI trading accounts at specialty level for stability and planning. • The policy enables three-to-five-year planning, supports strategic programs, and ensures changes are implemented without destabilising departments, with assurance provided after SLT review. • The policy is seen as an enabler for research, with support from the research management board and SLT, and that any budget movement will include associated costs to avoid risk. The CEO commended the team for getting the policy to where it has. **The Committee resolved that:** a) The new R&D Finance Policy to ensure compliance with Welsh Government policy was approved.	
FPC 22.07/4.4	**Finance & Performance Risks (scoring 20-25)** The DCG explained that after months of work, all organisational risks are now pulled out of a system that allows filtering by themes and scoring, aligning to the work. He noted the current output shows what is available, but more work is needed to make it usable at committee level. He stated that clinical boards were undertaking their own reviews and using this information in Clinical Board reviews. **The Committee resolved that:** a) It was noted the approach being implemented to align high-scoring (20+) organisational risks to Committee structures, improving visibility and governance oversight across all remits. b) The development of a consistent, organisation-wide approach to risk reporting and discussion within Committees was supported, including integration into forward plans and routine agenda items.	
FPC 22.07/5.0	**Any Other Business** No further business was raised.	
FPC 22.07/6.0	**Review & Close** To note the date, time and venue of the next Committee meeting: **Wednesday 16th September 2026 via MS Teams**	