Minutes of the Public Finance & Performance Committee Meeting
17th June 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
Judi Rhys	JR	Independent Member – Third Sector
Clive Curtis	CC	Independent Member - Community
Steve Riley	SR	Independent Member - University
Rachna Upadhya	RU	Independent Member - General
In Attendance:		
Robert Mahoney	RM	Deputy Director of Finance (Operational)
Catherine Phillips	CPH	Executive Director of Finance
Adam Roberts	AR	Executive Director of Strategic Planning
Catherine Wood	CW	Deputy Chief Operating Officer
Frankie Ogden	FO	Head of Corporate Governance
David Williams	DW	Head of Communications
Secretariat:		
Nikki Regan	NR	Corporate Governance Officer
Apologies:		
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
Susan Lloyd-Selby	SLS	Independent Member

Ref:	Agenda Item:	Action
FPC 2026/06/1.1	**Welcome, Introductions & Apologies** Rhian Thomas (RT), the Chair of the Committee welcomed everybody to the meeting in English and in Welsh.	
FPC 2026/06/1.2	**Declarations of Interest** No declarations of interest were raised.	
FPC 2026/06/1.3	**Minutes of the Finance and Performance Meeting held on 20th May 2026** The minutes of the meeting held on 20th May 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 20th May 2026 were held as a true and accurate record of the meeting.	
FPC 2026/06/1.4	**Actions following the Finance & Performance Meeting on 20th May 2026**	

	The Committee Chair – Rhian Thomas (RT) reviewed the action list, noting it was comprehensive and many items were scheduled for future meetings. The Executive Director of Finance – Catherine Phillips (CPH) – highlighted duplication of the grip and control standards action, suggesting deletion of the first entry and confirmed it will return in September. CPH explained three actions—improvement plan due in July, revenue funding request completed, capital request pending. The committee wants assurance the improvement plan is submitted on time. The CAVUHB Vice Chair – Ceri Phillips (CP) requested a verbal update on postage expenditure and potential savings CPH stated that CAVUHB spend approx. £1.5m per year on postage, noting the need to verify this figure due to recent postage increases. Work was ongoing to use the NHS app as the long-term solution for patient communication, but progress was slower than desired. The issue was related to patient communications; as an interim measure, CAVUHB switched from first to second class postage as standard, saving money but not improving performance due to slower delivery times. There is a need to continue digitalising communications, aiming for universal use of email, SMS, and digital records to eventually eliminate paper correspondence. Current practice is inconsistent, with some teams using all digital methods, some using a mix, and some not at all; accelerating this improvement project is necessary. The CAVUHB Chair – Kirsty Williams (KW) suggested the improvement project should allow patients to nominate a family member or carer to receive text messages or emails on their behalf, especially for those not digitally enabled or confident using digital tools. This would help patients manage multiple communications and support those who lack access or confidence with digital technology. The CAVUHB Vice Chair – Ceri Phillips (CP) shared a personal experience where they received a text message about an appointment, attended it, and then received a letter a week later about the same appointment, highlighting the inefficiency and risk of second-class postage. CPH described KW's suggestion as a helpful build for patient communication and said she would seek support from The Deputy Chief Operating Officer – Catherine Wood (CW) and the operational teams to address patient needs and wishes. She stated there is no lack of ambition and the project had been ongoing for over a year, but progress was slow. She noted the risk profile made CAVUHB reluctant to turn off email and paper, resulting in wasted money that should be saved. She emphasised this is a spend that should be reduced at pace and is part of wider financial improvement needed this year. The Independent Member for University – Steve Riley (SR) observed that patients can nominate someone (such as next of kin) to receive communications, but it was delivered inconsistently across CAVUHB. He suggested that engaging patients in the communication strategy and activating patient groups would lead to better outcomes. **The Finance and Performance Committee resolved that:** A) The Action Log for the Finance and Performance Committee was noted.	
FPC 2026/06/1.5	**Chairs Action since previous meeting** There were no Chair's Actions taken since the last meeting	
FPC 2026/06/2.1	**Financial Report – Month 2 Position (including savings tracker)** The Deputy Director of Finance (Operational) – Rob Mahoney (RM) highlighted the following points:	

- CAVUHB is at risk of not delivering the reported control total to Welsh Government (WG); the control total has not yet been accepted as achievable.
- The Board cannot file a balanced IMTP due to ongoing deficit and a savings gap; operational budget pressures currently show a small surplus, but this is being stress-tested.
- The recurrent savings programme was ambitious (£42.5m target), and is a key risk for achieving the control total (£86m deficit).
- Cash flow was stable early in the year but could become a serious issue by year-end if plan risks are not resolved.
- The underlying deficit is higher than last year due to new recurrent pressures; now £68m instead of £56m.
- At month two, CAVUHB is overspending against the savings plan, with a year-to-date deficit of £18.797m.
- The forecasted year-end deficit is £113m, which is £26.714m over the planned target; the main issue is the shortfall in the savings programme.
- There is a £5m risk related to JCC due to a unilateral 2% cost savings imposed on LTA income; arbitration is ongoing and could worsen the financial position if not resolved favourably.
- The savings pipeline is being reviewed; £28.176m shortfall currently, with some red pipeline ideas moved to amber/green but others removed as unrealistic for in-year delivery.
- If arbitration with JCC is lost, the deficit will increase by £5m; no decision yet from WG.
- The operational position shows a small surplus due to vacancies offsetting cost pressures, but this is not expected to last.
- Cash compliance is currently above target, but the capital allocation is limited and will likely increase later in the year for specific projects.

RT asked RM how long arbitration was likely to take and at what point a financial provision should be made for it.

RM responded that guidance from WG should have been received by now, but they were still deliberating. He expected a decision within approx. a month.

CPH noted the risk became apparent during the Planning and Commissioning cycle, especially in Quarter 4. She explained difficulty in building this into the plan, as it is a requirement for savings and would normally be agreed and included once identified, but this did not happen, leading to arbitration. If arbitration outcome was unfavourable, the deficit would need to be reassessed; she isn't keen to adjust the plan pre-emptively, as there is already enough savings risk in the current plan.

SR asked RM if savings ideas that are not going to deliver in-year are set aside, and whether those that could deliver in subsequent years are explored further.

RM explained that some savings ideas are not realistic and are discarded, but others are just a timing issue and may be appropriate for the pipeline in future years; they are not losing sight of these ideas, but delivery within this financial year to release cash is extremely unlikely.

RT noted disappointment at losing potential savings from the red pipeline and emphasised the importance of having accurate, validated data. They observed that CAVUHB seem to find it difficult to identify in-year opportunities and questioned how well the need to source ideas and opportunities is embedded throughout the organization. Rhian asked whether the process is limited to Clinical Board and senior leaders or if it is more broadly embedded and also inquired about options going forward given the continued gap and time constraints.

CPH described the CAVUHB culture as viewing transformation as a long-term process that often requires additionality but stated they have managed to persuade that additionality is not the answer; instead, transformation must occur within current resources. To achieve this, CAVUHB needs to take more risk than previously, as the current approach is not fast

enough to drive down costs. Catherine noted that the number they are off by has reduced, but clinical boards need help, guidance, and support to hold risks they do not feel able to manage.

CW observed that CAVUHB cannot continue with the same approach, as asking the same questions of the same people in the same way will yield the same outcomes. They have been working on leveraging what the operational teams are good at—doing tasks—and suggested shifting to a risk-based decision followed by a series of tasks, holding clinical boards to account for completing those tasks so the money falls out as a result.

KW expressed encouragement that the executive team recognised the current approach was not delivering what was needed and that a change was required. They highlighted the importance of this recognition and the need for a new approach that speaks to operational staff. She noted the importance for the board to reflect on CPH comment about risk, using the postage example: switching off paper communications after sending digital messages should be low risk, but the inability to do so reflects a risk concept that doesn't align with the system's actual risk. She stated that continuing with the current approach is not risk free; in fact, maintaining the status quo exposes the organisation to significant risk. The board needs to communicate that the status quo is perhaps the most risky option, not the safest.

CPH noted the need to drive quality outcomes upwards, emphasising that this is about pace and clarity. They stated that actions must be prioritised, focusing on a short list of deeper tasks that will improve the bottom line and support systemic transformation. She highlighted that CAVUHB cannot continue as it is, describing the current trajectory as "slipping down a slope that doesn't have a pleasant bump at the bottom." They stressed the need to reset onto an even keel and remain there with confidence.

RU asked how confident the team is that the recurrent savings made last year are truly recurrent this year, inquiring about reconciliation processes to ensure those savings continue and whether further savings can be achieved from last year's recurrent savings.?

RM explained there is a large amount of scrutiny from WG on the movement in the underlying deficit, with frequent testing alongside Clinical Board finance teams regarding assumptions and what has come out of their savings. He noted that some elements of funding last year were only provided non-recurrently, which impacts the calculation of the underlying deficit.

The Independent Member for Third Sector – Judi Rhys (JR) said she was listening carefully to the conversation on risk and agreed there needs to be more appetite for risk, as staying the same is not an option. She mentioned she does not recall a board conversation about an agreed risk appetite and questioned whether independent members need to be as signed up to the risk appetite as the executives.

KW stated JR's challenge about risk appetite was correct and requested to schedule a discussion on risk at a Board Development session.
(action) – schedule a risk discussion to take place at a Board Development session.

The Finance and Performance Committee resolved that:

a) The reported year to date position is an overspend of £18.797m with a planning deficit of £86.547m was noted.
b) The urgent need to derisk the £86.547m deficit plan was noted.
c) At month 2, it was noted there is adverse variance against plan of £4.372m, as a result of the £4.696m savings deficit and an operational surplus against plan of (£0.324m).
d) It was noted there is a gap of £28.176m against the £42.521m in year savings target, with £14.345m (33.7%) of green and amber schemes identified at Month 2
e) It was noted that the 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 was £34.391m 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 2026/062.2	**Operational Performance Update** The Deputy Chief Operating Officer – Catherine Wood (CW) highlighted the following points: • **Urgent and Emergency Care**: Attendances increased year-on-year; 12-hour waits decreased to 7.4%, nearing the targeted intervention goal; 24-hour waits and 45-minute handover delays also decreased. • **Out of Hospital Emergency Care**: Static position, but 4,000 more digital requests in April compared to the previous year, indicating a shift in access. • **Stroke Performance**: Provided a brief update from the stroke summit, highlighting work with WAST on pre-alert protocols, new stroke consultants focusing on EU, breach analysis meetings for every patient, and ongoing pathway improvements. • **Hospital Flow**: Lost 8,211 bed days in May, reduced by 500 from the previous month; committed to providing patient-level data in future reports. • **Cancer Position**: Malignant backlog continues to decrease; closed at 61.73% against a trajectory of 62%; considering stretching improvement trajectory to March for sustained deliverability. • **Diagnostics**: Endoscopy held position; cardiac diagnostics recovery plan in place; new clinicians appointed for systematic vetting; cancer and surveillance backlog addressed, reducing eight-week diagnostic position. • **Planned Care**: Forecast for 104-week waits aims for 2,240 patients by March; no patients waiting over three years; AQUA reporting system now live for theatres, with data comparable to previous system. • **Endoscopy**: Cancer and surveillance backlog solution implemented; ongoing work to further reduce eight-week diagnostic numbers; clinical vetting and pathway redesign underway. • **Primary and Community Care**: No material changes; working on aligning performance reporting with community by design. • **Mental Health**: Children and young people remain compliant; exploring in-sourcing for neurodevelopment pathway with non-recurrent funding; adult mental health part 2 compliance improving. JR welcomed the extra sessions for the capsule sponge programme and asked for clarification on whether these were two extra sessions per week or something else. They also noted that trans nasal endoscopy (TNE) was mentioned but not listed, and queried if TNE was a separate clinic or if there were any sessions for it. CW clarified that the capsule sponge sessions are 2.5 additional substantive sessions included in the job plans of the new clinicians. She explained that previous pump-priming funding for sponges from Welsh Government had ended in March, so the new sessions represent a recurrent benefit and a sustainable change in pathway design. She also indicated that building a sustainable workforce is part of the reason for the longer turnaround in endoscopy recovery, but did not provide specific details about TNE sessions or whether it is a separate clinic in this response. CC thanked CW for the overview and expressed concern about the high number of lost bed days, even though the figure had reduced. He asked if the team knew what proportion of those lost bed days were avoidable and what the expected reduction would be for the next quarter. CW responded that she did not know the answer off the top of her head but would come back with the figure regarding avoidable lost bed days. **(action) – Circulate a post-meeting action to provide figures on avoidable lost bed days.** RT asked about DNA and CNA, seeking clarification on the difference between the two terms.	

	CW explained that a patient can CNA (could not attend) twice before being removed from the waiting list, which means they notify the service in advance and request to rebook. DNA (did not attend) means the patient was given notice but did not show up, resulting in removal from the list. CP raised the point that performance measurement should reflect more community and primary care activity, including mental health, and questioned how this translates to system effects. CPH acknowledged this was discussed previously and admitted struggling with how to change the slide, noting that traditional reporting does not fit performance management for community by design. She agreed that the lens of alignment to community by design is helpful and will consider how to reshape performance measurement to reflect system effects. KW noted the detailed answer about endoscopy and highlighted that non-obstetric ultrasound (NOUS) was a concern for CAVUHB and WG, asking about assurance on progress. She also pointed out poor benchmarking in outpatients and requested information on actions being taken to address outpatient figures. CW responded that NOUS has seen a good improvement trajectory and the diagnostic position is now mainly affected by endoscopy and cardiac imaging, offering to bring data to the next meeting for assurance. She explained that for outpatients, there is ongoing work including addressing DNAs and CNAs, and a planned session with clinical leads to launch a new outpatient transformation strategy. This strategy will be more prescriptive, including changes to clinic templates, booking additional patients into clinics with high DNA rates, and reviewing new-to-follow-up ratios, moving from co-production to directive changes due to lack of progress. SR asked whether benchmarking has been done with other organisations of similar size to determine if the non-obstetric ultrasound issue is due to demand or capacity. CW replied she did not know and would need to check with the Diagnostics team. **(action) – Bring data on non-obstetric ultrasound progress and benchmarking to a future meeting.** CPH noted that the issue with non-obstetric ultrasound was due to a lack of sonography workforce, which led to efforts to recruit, train, and buy in additional staff, including paying enhanced overtime rates. This shortage contributed to the backlog, but measures have since been taken to address it, and non-recurrent solutions have been phased out as sufficient workforce is now in place. **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 2026/06/2.3	**Performance Productivity Oversight** The Deputy Chief Operating Officer – Catherine Wood (CW) highlighted the following points: • There is a need for a more consistent and systematic approach to performance and productivity management across directorates and clinical boards, moving away from ad hoc methods. • A new MDT (multi-disciplinary team) process focused on quality, productivity, and efficiency as pillars of performance, involving clinical, AHP, and admin teams. • The importance of empowering teams with relevant data via a Power BI dashboard, enabling real-time tracking and SPC (statistical process control) charts for performance metrics.	

	• Outlined a ward-to-board structure: weekly directorate meetings, systematic clinical board meetings, fortnightly meetings with Catherine, and executive performance meetings, all using standardised templates and data. • Listed key secondary care metrics tracked: DNA/CNA rates, theatre and clinic utilisation, urgent/emergency care, length of stay by specialty/ward, admissions, estate use, and discharges. • Confirmed the dashboard is live, teams are using it, and the first executive performance and productivity board meeting is scheduled. • Stated that future reporting will shift from narrative to visual run charts, requiring clinical boards to explain performance trends and drivers. • Mentioned ongoing work to replicate the approach for primary/community care and mental health, and to integrate it with broader performance management systems. • Noted the formation of a dashboard development group to refine and co-produce improvements, with early feedback showing optimism and requests for subspecialty-level data. SR stated that the new approach is a step change needed for CAVUHB, suggesting that a more directive use of consultant SPAs should help address issues highlighted in performance reports. He emphasised that this should influence how the board is reported to, providing better assurance and focus for driving organisational performance. RT asked how the new performance and productivity oversight approach has been received by the clinical boards and what feedback or reactions have been observed so far. She also asked how CW envisages the intelligence gathered from this methodology being fed back into committee and board, so it can be used effectively going forward. CW explained that implementing the new approach was a journey, with her and Adam working hard to pull it together. She described initial mixed reactions from directorates—some felt it was unnecessary; others saw it as extra work—but after listening to the teams, everyone was supportive but anxious about the "how." She noted there is now a coalition recognising the need, and that it will be easier for teams in the long run, especially with the BI dashboard making data visible and accessible. Catherine also mentioned that eventually, some narrative can be removed from reports, relying more on run charts to show improvement over time. AR stated that the best way to improve data is to use the same data and tools for service level improvement as are used for discussions and assurance, which will enhance the quality of data reviewed in meetings. KW recognised this as a step change for CAVUHB in achieving better assurance around productivity and performance. She noted the team has listened to feedback from independent members, aiming for less narrative and more data, and hopes this approach responds to their requests. She also highlighted that the QMS and current reporting demonstrate a real step forward in assurance systems for CAVUHB. **The Committee resolved that:** a) The revised approach to performance and productivity was noted.	
FPC 2026/05/2.4	**BAF Longterm Finance** The Deputy Director of Finance – Robert Mahoney (RM) highlighted the following points regarding long term finance: • Stressed the importance of sustainable service transformation, not just short-term annual planning. • Explained previous financial projections, now corroborated by the McKinsey report, confirming ongoing financial challenges. • Highlighted the need for productivity improvements, right-sizing workforce, and better planning and performance assessment. • Noted the development of an Integrated Improvement Plan to address these issues. • Emphasised aligning McKinsey recommendations with organisational planning for financial sustainability.	

	RT asked what the findings and corroboration from the McKinsey report mean for operational planning and longer-term expectations, specifically requesting when the committee can expect further updates ("Chapter Two") on where this work is heading. CPH noted there are some immediate actions we need to undertake. This sits wider than finance and she was unsure how much would be buried in the integrated improvement plan. We need to build a plan that gives us confidence. AR stated that CAVUHB cannot follow someone else's plan and needs one coherent plan, mentioning that this has been summarised in their letter to WG in response to the rapid assessment of the annual plan, and suggesting it would be helpful to discuss this at the Board Development session. **The Committee resolved that:** a) The BAF Long term finance was discussed and noted.	
FPC 2026/05/4.1	**Monthly Monitoring Return – Month 1** The monthly monitoring return for month 1 was noted. **The Committee resolved that:** a) The monthly monitoring return for month 1 was noted.	
FPC 2026/05/5.0	**Any Other Business** No further business was raised.	
FPC 2026/05/7.0	**Review & Close** To note the date, time and venue of the next Committee meeting: **Wednesday 22nd July 2026 via MS Teams**	