

**Minutes of the Public Finance & Performance Committee Meeting  
22<sup>nd</sup> April 2026  
Via MS Teams**

To view a recording of this meeting, please [click here](#):

<b>Chair:</b>		
Rhian Thomas	RT	Independent Member – Capital, Estates & Facilities
<b>Present:</b>		
Kirsty Williams	KW	CAV UHB Chair
Judi Rhys	JR	Independent Member – Third Sector
Clive Curtis	CC	Independent Member - Community
Ceri Phillips	CP	Health Board Vice Chair
David Edwards	DE	Independent Member – Digital
Lorna McCourt	LM	Independent Member – Trade Union
<b>In Attendance:</b>		
Suzanne Rankin	SR	Chief Executive Officer
Matt Phillips	MP	Director of Corporate Governance
Catherine Phillips	CP	Executive Director of Finance
Andrew Gough	AG	Deputy Director of Finance (Strategic)
Paul Bostock	PB	Chief Operating Officer
Robert Mahoney	RM	Deputy Director of Finance (Operational)
<b>Additional Attendees:</b>		
Emily McDonald	EM	Graduate Management Trainee
Em Wilkinson-Brice	EWB	Independent Assessors
<b>Secretariat:</b>		
Nikki Regan	NR	Corporate Governance Officer
<b>Apologies:</b>		
Rachna Upadhya	RU	Independent Member – General
Susan Lloyd-Selby	SLS	Independent Member – Local Authority

Ref:	Agenda Item:	Action
FPC 2026/03/1.1	<a href="#">Welcome, Introductions &amp; Apologies</a>	
FPC 2026/03/1.2	<a href="#">Declarations of Interest</a>  No declarations of interest were raised.	
FPC 2026/03/1.3	<a href="#">Minutes of the Finance and Performance Meeting held on 18<sup>th</sup> March 2026</a>  The minutes of the meeting held on 18 <sup>th</sup> March 2026 were received and confirmed as a true and accurate record.  <b>The Finance Committee resolved that:</b> a) The minutes of the Finance and Performance Committee meeting held on 18 <sup>th</sup> March 2026 were held as a true and accurate record of the meeting.	
FPC 2026/03/1.4	<a href="#">Actions following the Finance &amp; Performance Meeting on 18<sup>th</sup> March 2026</a>  The Action Log following the meeting held on the 18 <sup>th</sup> March 2026 was received and discussed.  The Chair asked whether the committee needed to wait until May for an update on the capsule sponge for upper GI cancer pathway, or if a note could be circulated to committee members prior to the meeting, unless it was going to be a substantive item.  <b>The Finance and Performance Committee resolved that:</b>	

	A) The Action Log for the Finance and Performance Committee was noted.	
FPC 2026/03/1.5	<p><a href="#">Chairs Action since previous meeting</a></p> <p>There were no Chair's Actions taken since the last meeting</p>	
FPC 2026/03/2.1	<p><a href="#">Financial Report – Month 12 Position (including savings tracker)</a></p> <p>Andrew Gough (AG), the Deputy Director of Finance (Strategic), provided the following summary of the report to the Committee:</p> <ul style="list-style-type: none"> <li>• A year-end deficit of £56.097m, which is £136k better than the planned deficit.</li> <li>• Achieved the planned deficit despite significant financial challenges throughout the year.</li> <li>• Delivered £32m in savings, operated within the capital resource limit and met the 95% creditor payments compliance target.</li> <li>• Figures were provisional; draft accounts to be submitted for audit and internal review.</li> <li>• Three-year rolling deficit stood at £100m; would need a £44m surplus to achieve break-even duty.</li> <li>• Year-end position broken down by clinical board, showing variable performance—some boards exceeded control totals, others did not</li> <li>• Deep dive meetings and grip/control actions from month 5 onwards were key to recovering the position and hitting the plan.</li> <li>• Funding streams became more certain as the year progressed, aiding the financial position.</li> <li>• Emphasised the need for earlier grip/control measures in future years to avoid late recovery.</li> </ul> <p>The Committee Chair / Independent Member Capital Estates &amp; Facilities – Rhian Thomas (RT) noted that in the first five months of last year, CAVUHB were slipping away from the provisional financial plan, with variation between clinical boards in reaching expected control totals. She observed that the month 5 period marked a significant shift, stopping the slippage and recovering to hit the planned deficit by month 12. She referenced narrative about deep dives and asked if the shift at month 5 was due to a cultural change or increased controls, requesting AG to explain and relate this to variations by clinical board and implications for future planning</p> <p>AG stated that CAVUHB did not have a firm plan in place at the start of the financial year, which lead to recovery mode and uneven impact across clinical boards. He indicated a similar position was expected for the upcoming year, with planning challenges persisting. He explained that deep dive meetings were instrumental in regaining control, especially from month 5, when the forecasted deficit was £8m worse than planned. He noted these actions focused on workforce control and were sustained through in-person meetings with executives and clinical boards. He highlighted that certainty in funding streams improved as the year progressed, which aided the financial position. He added that the combination of deep dive actions and funding certainty was crucial, and without these, the planned deficit would not have been achieved.</p> <p>The Chief Operating Officer – Paul Bostock (PB) noted that restrictions around vacancy control were implemented, which helped achieve financial goals but caused an ill feeling among staff. He explained that these measures were not recurrent and were not embedded, and CAVUHB had not yet reshaped the workforce to remove those posts. He mentioned that this year started with four executive reviews, with some directorates wanting to recruit into previously held vacancies, but this cannot be allowed as it would increase the run rate. He stated that monthly workforce and finance deep dives would need to be reinstated from next month to address these issues in more detail.</p> <p>The Vice Chair – Ceri Phillips (CPH) asked to what extent CAVUHB would incorporate the thinking that spending in some areas could generate savings in other boards moving forward. He linked this to the need for shifting towards primary and community service provision rather than reliance on hospital care.</p> <p>AG stated that to create headroom for shifting resources and spending in primary care, a desperate plan was needed to move this forward. He explained that currently, there was no reduction in demand coming through secondary care to provide that headroom, so without taking a leap of faith or increasing the deficit to build community capacity, CAVUHB remained on the current loop.</p> <p>The Chief Executive – Suzanne Rankin (SR) highlighted that the strategy was about delivering strategic shifts, reinforcing the need to create financial headroom and capacity to achieve these shifts. She assured the committee that CAVUHB did not wait until month 5 to address the plan; green and amber savings were secured early, reducing the forecast deficit by £2m. She stressed the importance of integrated activity, workforce, and cost planning from each clinical board, noting ongoing</p>	

struggles to secure this from all boards. She mentioned working increasingly closely with colleagues to achieve goals but now questioned whether the capability exists and what is needed to deliver the financial outturn. She reflected that the main issue was not a loss of grip and control, but an inability to plan effectively to the required scale.

PB noted the need for plans to keep frail, elderly patients at home, avoiding unnecessary admissions and bed days, rather than shifting resources to more expensive minor surgery in primary care. He stressed the importance of aligning community by design plans with what GPs want to do, highlighting that increasing minor surgeries and joint injections would drive up costs and not help. He pointed out a failure to plan, as many are stuck in the mindset that work can only be done if more resources were provided, while the real challenge was using existing resources more effectively and efficiently. He explained that people struggle to see how they can make a £40m savings plan and still deliver all required work, indicating a lack of ability to see how to achieve this.

CPH agreed with PB that it was essential to do the right things in the right place and acknowledged there were current examples where this wasn't happening. He emphasised the need for headroom and space to determine what can be moved effectively without compromising quality or requiring additional resources. He noted that when some people were admitted to hospital, their chances of being discharged diminish, highlighting the importance of reducing length of stay. He stated that by reducing length of stay, resources and beds can be freed up to meet additional demands and channelled into appropriate interventions in primary and community care.

The UHB Chair – Kirsty Williams (KW) recognised the huge effort made to reach the current position but highlighted the failure to meet statutory obligations, noting the deficit almost doubled from the previous year and had doubled the year before that, with a worsening trajectory for the next year. She stressed the need to be realistic about the financial situation and questioned what was learned over the last year regarding managing clinical board performance and making savings. She asked how the £32m in savings (less than 2% of the budget) benchmarked against expectations for an organisation of this size, and what would be a regular or recovery savings plan. She wanted to understand what lessons from last year could be applied to improve the position this year, especially since there wasn't a complete plan at the start of the year, and how to avoid being in the same situation next year without a plan.

AG stated that for an organisation of their scale, 2% savings was the expected benchmark, equating to approx. £40m annually. He noted that only £32m was delivered this year, and not all of it was recurrent, which meant the ambition was not fully met. He highlighted that there was a shift in culture, with more focus on integrating activity, workforce, and financial planning. He stressed the importance of starting the year with a clear workforce plan. He explained that grip and control measures were helpful but only went so far; transformational service changes were needed to bridge the gap. He acknowledged that CAVUHB had further to go, especially for 2026/27, and that delivering £40m savings per year will not close the deficit quickly enough.

RT noted that public sector payment compliance previously struggled to meet the target, but it now appeared to be consistently above 95%, suggesting that root causes were addressed and the process was running smoothly.

KW stated this was not a good place to start the financial year. She pointed out there was no level of confidence in the ability to deliver the savings plans. She asked what steps executive colleagues were taking to finalise savings targets and provide assurance to the Board about deliverability, and when the Board would have clarity on this.

The Chief Executive – Suzanne Rankin (SR) asked for clarification on the savings plan target and the figures, distinguishing between the original plan and additional items from the opportunity pipeline. She noted there is a plan currently submitted (plan 1.0) and a further plan in train (plan 1.1) with additional items. She wanted clarity on which plan is being discussed and to understand the extent to which the original plan is being delivered, as well as the remaining gap and the opportunity for an enhanced or recovery plan. She raised the debate about the capability of clinical boards to generate and deliver these plans, noting the cultural shift is starting but delivery must follow. She added that assistance would be needed for delivery and this would need to be brought to the Board for proposition and discussion.

AG confirmed that against the original target of £42.5m, £9m was identified on the savings tracker, with no opportunity pipeline delivery yet identified in green and amber from the agreed schemes. He stated that each of the schemes being worked up has a lot of granular detail and was itemised, but where it is just a theme, the full detail is not yet available to fill that part.

PB clarified that it was not unclear to the clinical boards; every clinical board knows their savings target, which is detailed in the relevant documentation. Some boards have higher targets due to non-recurrent issues carried over, but all are aware of their specific ask. He emphasised the need to work up the pipeline ambitions and opportunities, integrate them into the savings plan, and return by the end of May with a clearer, more complete picture. He acknowledged that while the overall situation may appear confusing, the targets are clear to those responsible, and the next step is to develop the details and identify where additional support will be needed to deliver the savings.

The Executive Director of Finance – Catherine Phillips (CP) clarified that page 10 of the papers showed how the savings could be delivered, but there was still £3.4m outstanding and productivity was yet to be fully explored and described. She explained that the savings plan progress on page 11 was the real and up-to-date position, and that the original opportunity pipeline and McKinsey work were being updated to inform the plan. She emphasised that some elements in the plan were transactional and need to be managed as such, while others require service change and must be built up by the service, with a focus on deliverability and understanding milestones and activities. She stated that all this needs to be done by May to de-risk the £86m deficit as a first step.

The Independent Member ICT – David Edwards (DE) highlighted the need to define and de-risk the plan but cautioned that "no plan survives first contact with the enemy," referencing the unpredictability of external factors. He noted rising inflation and the likelihood of increased costs due to the cost-of-living crisis and global instability, especially events in the Middle East. He sought reassurance that the team was considering these risks and emphasised the importance of tracking whether missed targets are due to internal actions or exceptional, unforeseeable circumstances. He stressed the need for a clear narrative to explain when targets are not met and to distinguish between controllable factors and external shocks.

PB explained that the Welsh risk pool resulted in a £21m hit to the plan this year, which we are struggling to mitigate. Without this, the deficit would be around £60m, close to the £56.2m at year-end. He noted that such left-field issues arise, and while explaining them is possible, they are not given credit for it, as they were told to manage it despite raising the issue.

CP stated that costs were tracked logically, with estimates based on inflation (CPI), which allowed for legitimate monitoring throughout the year. She mentioned that the committee regularly reviews cost pressure analysis to assess accuracy, with Andrew providing updates, and noted that fluctuations are typically consistent with estimates. She acknowledged that the root cause of sickness requires further analysis, and highlighted those recent escalations in costs, such as those from price inflation as a result of the restricted supply of goods from war and clinical negligence, had not been seen in previous years.

SR mentioned seeing a benchmarking paper with measures across NHS Wales, which she intends to share with the board to provide context on their position relative to other health boards. She noted that the data could highlight areas where Cardiff and Vale UHB is an outlier, particularly in demand analysis, prompting further questioning about whether this is due to service portfolio, tertiary status, or other factors. She suggested using this benchmarking information for a future board conversation to explore these outlier areas and understand their implications.

**The Finance and Performance Committee resolved that:**

- a) The reported year to date position is an overspend of £56.097m against the planned deficit of £56.233m was noted.
- b) The month 12 operational overspend against plan of £0.202m and the (£0.339m) savings surplus was noted.
- c) The outturn against the in-year savings target, with £32.339m (101.1%) of green schemes identified at Month 12 against the revised £32m target was noted.
- d) The delivery of the draft outturn is contingent on confirmation of the remaining outstanding Welsh Government allocations which totalled a net reduction of (£49.844m) at the 15<sup>th</sup> April 2026 was noted.
- e) The combined recurrent savings shortfall and recurrent operational pressures of £12.5m, which are adversely impacting the deteriorating underlying deficit being carried into 2026/27. The underlying deficit entering 2026/27 is currently assessed at £68.7m, which is £12.5m higher than the 2025/26 forecast outturn of £56.2m was noted.
- f) The Draft 2026/27 Planned Deficit of £86.5m and progress against the 2026/27 Savings Plan was noted.

Paul Bostock (PB) – Chief Operating Officer provided the following summary of the report to the Committee:

- **Urgent & Emergency Care:** Demand increased by 3.6%, equating to an extra day's work monthly; 12-hour waits improved to 8%, best in NHS Wales, but still high; 45-minute ambulance handover performance at 90%, with average handover time of 30 minutes (standard is 15 minutes).
- **Stroke:** Four-hour ward performance improved but below target; CT scanning capacity was a major constraint due to only one scanner serving multiple needs; stroke summit postponed but focus remained on pre-hospital issues, EU pathway, and length of stay.
- **Pathway of Care Delays:** 119 patients delayed in physical health beds (average delay 37 days); 37 mental health patients delayed (average 93 days); total bed days lost improved by 3,100 compared to last year.
- **Cancer:** February performance at 54.5%; backlog reduced to 335 patients; six tumour sites met 75% standard; urology backlog halved; performance expected to improve in March.
- **Diagnostics:** March ended with 6,400 patients waiting over 8 weeks; significant reduction from 17,000 in December 2024; MRI and non-obstetric ultrasound expected to meet targets by Q2; endoscopy remains a challenge.
- **Planned Care:** 335 patients waiting over two years, best in five years; no patients waiting over three years; 31,000 additional first outpatient appointments delivered; backlog reduction attributed to non-recurrent funding and outsourcing.
- **Community Care:** 190,000 district nursing visits year-to-date; three and a half thousand patients cared for daily in their own beds, highlighting community team impact.
- **Mental Health:** Children and young people standards (28-day assessment/treatment) met since September 2024; neurodivergence backlog cleared but funding is non-recurrent; adult standards also met, with community teams seeing 25,000 clients monthly.
- **Productivity & Performance:** New monthly exec-led oversight group and weekly directorate meetings to focus on performance and productivity, covering standards, theatre efficiency, outpatient efficiency, and reporting to the committee.

CPH noted that the new mental health strategy was predicated on open access, which would require work to ensure appropriate individuals were dealt with in the right way. He highlighted that WG would expect increased liaison with the third sector to address tier 0 entries, emphasising the need to configure the service properly as the strategy moves forward. He expressed that the strategic approach may further improve mental health services, acknowledging significant improvements already made.

PB explained that the biggest block to reducing twelve-hour waits is getting patients out of EU in a timely way, and that the next step change requires decongesting EU. He mentioned that the team recently had a great idea for reconfiguring the medical model and patient cohorting, but he had to point out that they hadn't included seven-day working or an extended working day, which were necessary for real improvement. He reiterated that to make the next step change, the focus needs to be on decongesting EU, as mornings often start with majors full of patients waiting for admission.

KW acknowledged that in some areas, CAVUHB is at its best level of performance, which required significant work and effort. She expressed concern about the delay of the stroke summit and requested reassurance that there would not be a loss of grip on stroke analysis, noting that stroke performance was worse than it was a few years ago. She observed a mixed picture at year-end, with some targets met (either WG's or internal), but in other areas, performance targets were not achieved.

PB noted that the organisation previously reached an A grade in stroke performance, but the criteria have since changed, making it much harder to deliver. He committed to bringing back an update on stroke next month to provide assurance, confirming an action for a stroke update in May. He stated that, with the exception of diagnostics, the organisation has delivered on what was promised, distinguishing between WG asks and internal commitments. He suggested bringing a brief slide deck to the next committee meeting outlining how productivity and performance will be managed, including metrics and expected outcomes. He emphasised that the team tries not to over promise and aims to be ambitious yet realistic in their plans.

**Action - Stroke Pathway Improvements** - PB to provide a wider update on endoscopy capacity, including capsule sponge for upper GI cancer, as part of a substantive paper.

**Action - Diagnostic Performance Briefing** - PB to bring a written briefing on diagnostic performance and lessons learned, including steps to avoid previous issues.

**Action - Productivity & Performance Oversight** - PB to present the structure and aims of the new productivity and performance oversight group.

	<p><b>The Committee resolved that:</b></p> <p>a) The year-to-date position against key organisational performance indicators for 2026-27 and the update against the Operational Plan programmes was noted.</p>	
<p>FPC 2026/03/2.3</p>	<p><a href="#"><u>Ministerial Performance Standards</u></a></p> <p>PB highlighted the following points for the ministerial performance standards:</p> <ul style="list-style-type: none"> <li>the submitted plan does not have a line of sight on achieving zero 104-week waits or zero 8-week diagnostic waits and referenced additional standards for clinical coding and neurodivergence.</li> <li>He outlined what it would take to reach zero 104-week waits, estimating a need for £9–10 million, mainly due to a recurrent core capacity deficit in specialties.</li> <li>He clarified that most remaining long-wait patients now require treatment, which is harder to deliver than outpatient clinics or diagnostics.</li> <li>For diagnostics, Paul stated that the targeted intervention requirement is 80% of patients waiting under 8 weeks, but the ministerial expectation is 100%. He noted that endoscopy is the main challenge, with a recurrent capacity deficit and an estimated cost of around £5 million to clear the backlog.</li> <li>He stressed that productivity improvements alone cannot close these gaps; additional funding is required.</li> <li>Paul summarized that delivering both the 8-week diagnostic and 104-week treatment standards would require about £14 million, which is not currently available and would increase the deficit.</li> <li>He also mentioned smaller investment needs for neurodevelopment and clinical coding standards.</li> </ul> <p>CPH noted the significant cost implications of delivering the standards and suggested considering the cost implications of not delivering, such as patient deterioration and longer waits affecting eventual procedures. He asked if it was possible to factor in these impacts, noting that spending £14m to resolve diagnostics and long waits could prevent further negative consequences.</p> <p>PB responded that while the percentage of long-wait patients was small compared to the total waiting list (about 115k), this did not help the individuals waiting, and he expressed uncertainty about the broader impact.</p> <p>KW highlighted the challenge faced, noting that despite the significant savings plan and efficiency efforts, it comes down to choices made daily within CAVUHB. She questioned where the space exists for a broader discussion about what activities need to be stopped, so resources could be reallocated to deliver performance outcomes or improve the bottom line.</p> <p>CP commented on the need to discuss all resources deployed, emphasising that after exhausting current resources, the conversation leads to additionality. She stressed the importance of continuing this conversation and questioned how to have more radical discussions about service change and transformation.</p> <p>PB stated he would refine the numbers, clarify productivity assumptions, and ensure accuracy for diagnostics. He explained this work would be included in the broader list of priorities for board consideration.</p> <p>RT mentioned that guidance on whether the investments were recurring or non-recurring would be helpful for some of these elements.</p> <p>KW asked how the actions align to CAVUHB's risk tolerance and appetite, emphasising the need for the board to collectively understand what they were willing to withstand regarding finances and performance.</p> <p>PB stated that on the 104-week position, CAVUHB were not alone, as every other health board has reported a similar situation and received similar feedback from WG.</p> <p><b>The Committee resolved that:</b></p> <p>a) The Committee noted the content of the report.</p>	
<p>FPC 2026/03/3.1</p>	<p><a href="#"><u>Items for Approval / Ratification</u></a></p> <p>No Items</p> <p><b>The Committee resolved that:</b></p>	

	a) There were no items for approval.	
FPC 2026/03/4.1	<p><a href="#"><u>Monthly Monitoring Return – Month 11</u></a></p> <p>The monthly monitoring return for month 11 was noted.</p> <p><b>The Committee resolved that:</b></p> <p>a) The monthly monitoring return for month 11 was noted.</p>	
FPC 2026/03/5.0	<p><a href="#"><u>Any Other Business</u></a></p> <p>No further business was raised.</p>	
FPC 2026/03/7.0	<p><a href="#"><u>Review &amp; Close</u></a></p> <p>To note the date, time and venue of the next Committee meeting:  <b>Wednesday 20<sup>th</sup> May 2026 via MS Teams</b></p>	