Cofnodion heb eu cymeradwyo o gyfarfod y Pwyllgor Strategaeth a Chynllunio/ Unapproved Minutes of the Strategy and Planning Committee Meeting

Date of Meeting: **09:00, Tuesday 28 April 2026**
Venue: **Microsoft Teams Meeting; HDD Picton - Dolau Cothi**

Present:
Mr Winston Weir, Independent Member/ Chair
Mr Maynard Davies, Independent Member/ Vice Chair
Mr Michael Imperato, Independent Member
Mrs Eleanor Marks, Independent Member/ HDUHB Vice Chair
Mr Neil Prior, Independent Member

In Attendance:
Mr Lee Davies, Executive Director of Strategy and Planning
Mr Andrew Carruthers, Chief Operating Officer
Mr Huw Thomas, Director of Finance
Mrs Joanne Wilson, Director of Corporate Governance/Board Secretary
Ms Alwena Hughes Moakes, Communications and Engagement Director
Dr Bruce Bolam, Deputy Director Public Health, deputising for Dr
Dr Ardiana Gjini, Executive Director of Public Health
Mr Shaun Ayres Director of Delivery (part)
Mrs Helen Mitchell, Committee Services Officer

Items SPC(26)39, SPC(26)40 and SPC(26)46
Mr Shaun Ayres, Director of Delivery

Items SPC(26)41 and SPC(26)42
Ms Bethan Lewis, Assistant Director of Public Health
Dr Bruce Bolam, Deputy Director Public Health
Mr Craig Jones, Prevention & Population Health Improvement Manager

Item SPC(26)42
Mr Alistair Fisher, Public Health Programme Manager

Item SPC(26)43
Ms Eldeg Rosser, Head of Capital Planning

Item SPC(26)44
Mr Simon Chiffi, Head of Operations
Mr Julian Wheeler Jones, Discretionary Capital Projects Manager

Item SPC(26)45
Mr Nathan Davies, Senior Project Manager

Item SPC(26)46
Mr Alex Martin, Principal Programme Manager

Minutes Ref.	Item	Action
SPC(26)34	**Welcome and Apologies** Mr Winston Weir welcomed members to the Strategy and Planning Committee (SPC) meeting reminded members of the purpose of the Committee. He noted that agenda planning had been intentionally reshaped to allow deeper scrutiny and a more assurance-focused discussion, particularly in relation to planning maturity, integration of enabling strategies, and the Committee's advisory role to the Board. No apologies had been received.	
SPC(26)35	**Declarations of Interests** None were declared.	
SPC(26)36	**Minutes from the Strategy and Planning Committee meeting on 26 February 2026** The minutes of the SPC meeting held on 26 February 2026 were **APPROVED**.	
SPC(26)37	**Table of Actions of the Strategy and Planning Committee meeting on 26 February 2026** The table of actions from the previous meeting was discussed. Mrs Eleanor Mark raised a query about the completion of the action related to enhancing population health metrics, seeking clarification on when these metrics would be seen. Dr Ardiana Gjini indicated that the metrics for the escalation domain would be included as routine business, while the population health domain metrics could be presented in a deep dive at the next Committee meeting. Another action discussed involved children and young people in digital development, which was agreed to be taken into consideration in future plans.	**AG**
SPC(26)38	**Strategy and Planning Committee 2025-26 Annual Report** Mrs Joanne Wilson presented the SPC 2025-26 Annual Report, indicating that the report summarised the Committee's activities over the past year, including reflections from the Chair. Key highlights included progress on refreshing the A Healthier and Mid and West Wales (AHMWW) Strategy, advancements in clinical services, and the importance of coordination between finance, planning, digital, and population health mechanisms. The Committee approved the annual report for onward ratification to the Board, noting the need to double-check the accuracy of the rollout dates for Electronic Prescribing and Medicine	**HT**

Administration (ePMA). Mr Weir highlighted progress made during the first full year of the Committee, particularly regarding public engagement and the strategic refresh. Members noted continued opportunities to strengthen integration across finance, digital, workforce and population health.

Decision:
The Committee **APPROVED** the SPC 2025-26 Annual Report pending confirmation of the ePMA rollout dates.

SPC(26)39 Assurance and Risk Report

Mr Shaun Ayres joined the meeting.

Mrs Wilson introduced the Assurance and Risk Report, advising that two corporate risks were currently assigned to the Committee, alongside seven audits and inspections, as well as Welsh Health Circulars (WHCs) and Ministerial Directions. She highlighted that the risk relating to the Annual Plan had increased in line with recent Welsh Government correspondence, and that a new capital risk had been identified.

Mr Lee Davies reinforced the increase in corporate risk linked to the Annual Plan and the emergence of the capital risk. The Committee welcomed confirmation that the 2025–26 Capital Resource Limit (CRL) had been achieved with minimal variance, recognising this as a significant accomplishment.

Discussion focused on the risk rating applied to the Integrated Medium Term Plan (IMTP). Mr Weir suggested that the target risk score may understate the uncertainty inherent in long-term financial planning. Mr Shaun Ayres acknowledged the challenge of setting appropriate target risk scores, noting that delivery of the current year's plan would be critical in determining the organisation's financial position in future years, particularly moving into 2027–28.

The Committee considered audit and inspection findings, with concern raised regarding overdue actions, particularly those associated with Community and Integrated Medicine. Mr Andrew Carruthers clarified that many of these actions originated from a single Urgent and Emergency Care (UEC) audit report rather than multiple systemic issues. Concern was also expressed regarding the removal of agreed implementation dates in some cases. It was explained that ongoing work to redesign service models had necessitated a realignment of audit recommendations, with updated timelines and clear links to service redesign activity to be presented to the next Committee meeting. **AC**

The discussion included a point about the responsibility for certain audit-related items, which might be directed to the Quality, Safety and Experience Committee (QSEC).

Members considered the response to Welsh Government correspondence, which emphasised that the Annual Plan

remained unacceptable and stressed the need for more comprehensive savings and operational delivery plans, alongside the de-escalation criteria. These include submission of an acceptable Annual Plan, evidence of integrated planning, progress on the Clinical Services Plan (CSP), the Planning Maturity Matrix, and regional planning. The challenges of meeting these requirements in the context of financial and performance pressures were acknowledged.

Mr Ayres confirmed that the current assessment is based on last year's Planning Maturity Matrix, with an updated position to be presented at the next Committee meeting. The establishment of planning roles within Clinical CareGroups (CCGs) was noted as a means of strengthening planning capacity and addressing known gaps. Mrs Eleanor Marks emphasised the need for a coordinated, cross-committee approach to respond to the issues raised.

Decision:
The Committee, in relation to the areas presented **RECEIVED ASSURANCE**:

Risk Management
That identified controls are in place and working effectively; that all planned actions are credible and deliverable, and in line with agreed plans, and will be implemented within stated timescales and will reduce risks further and/or mitigate the impact should risks materialise.
Audits, Inspections and Regulatory Reports
On the management of recommendations raised in audit, inspection and regulatory reports within their area of responsibility, particularly in respect of confirming the full implementation of recommendations, any barriers to delivery and subsequent impacts of non/late delivery, and assurance that the risks associated with these are being managed effectively.

SPC(26)40 **Targeted Intervention Update**

Mr Ayres presented the Targeted Intervention Update, referencing the Welsh Government letter dated 22 April 2026, which indicated that the Health Board's Annual Plan remained unacceptable and unsupportable, advising that the associated corporate risk score had been increased to reflect the scale of the financial challenge and the difficulty of delivering both required savings and performance improvements within existing resources. It was noted that Welsh Government's concerns related not only to the financial gap but also to the lack of sufficiently detailed and integrated planning underpinning delivery.

The Committee discussed the implications of the letter, noting that no additional funding would be available to support recovery and that any improvements need to be delivered within current allocations. It was acknowledged that any national funding would require redistribution rather than representing new investment. Mr Ayres highlighted that the forthcoming Board report would build on

the Annual Plan, setting out planned savings alongside associated operational consequences.

Mr Ayres clarified that the Strategy and Planning Committee's primary focus should be on ensuring the development of clear, robust and fully integrated plans, demonstrating alignment across workforce, financial and operational elements. Mr Lee Davies confirmed that steps were being taken to strengthen planning capability through the establishment of dedicated planning posts within CCGs.

The Committee also considered progress on the CSP. Assurance was provided that work remained on track against agreed milestones, with further engagement planned. It was agreed that assurance could be taken in relation to the process at this stage, rather than final service models. The Planning Maturity Matrix was referenced, with a further update scheduled for the next Committee meeting.

Overall, the Committee acknowledged the significant risks associated with the Annual Plan and planning maturity, however agreed that assurance could be provided to the Board on the approach being taken, subject to continued development and strengthening of planning arrangements.

Decision:
The Committee:
NOTED that**:**

- The overall position across the five criteria: two at Alert (annual plan and planning maturity), two at Advise (integrated planning and regional planning), and one at Assure (Clinical Services Plan)
- The WG scrutiny session letter of 31 March 2026, which confirmed that a deficit plan cannot be supported and that the financial position must not deteriorate
- The corporate risk score for the Annual Plan (Risk 2212) has increased from 12 to 16, reflecting the deterioration in the planned financial position
- The current position matrix against the Planning Maturity Matrix shows four of nine domains at RED, indicating that planning maturity progress has not yet translated into consistent organisational delivery

ADVISED

- The Health Board will undertake a financial de-risking exercise and assess what is required to deliver a trajectory to the £22.1m target control total in Q1 that will be presented to the appropriate committees and Board at the earliest opportunity

RECEIVED ASSURANCE that:

- The Clinical Services Plan process and roadmap (Criterion 7) demonstrate mature programme management and organisational readiness for complex transformation

- The assessment methodology is evidence-based, drawing directly on WG correspondence, the Annual Plan, the Planning Maturity Matrix self-assessment, and the current position matrix

SPC(26)41 PO10: Population Health and Prevention Year End Report

Ms Bethan Lewis, Dr Bruce Bolam and Mr Craig Jones joined the meeting.

Ms Bethan Lewis presented the Planning Objective (PO) 10: Population Health and Prevention End of Year Report, indicating that the majority of milestones were rated amber. She explained that this reflected delivery being on track, while recognising that many programmes span multiple years and will continue into the next planning cycle. She emphasised that the amber rating should be interpreted as ongoing progress rather than delay or underperformance.

In presenting the outcomes, Ms Lewis drew attention to several areas of measurable progress, reporting that smoking cessation validation rates had improved significantly over the course of the year, increasing from approximately 8% at the beginning of the reporting period to 26% at year end, exceeding the locally agreed target of 20%. She clarified that this metric related specifically to carbon monoxide validation and did not reflect overall cessation success rates, which remained above national expectations. Ms Lewis also reported improvements in early years and school-based interventions, noting that the proportion of schools engaged in emotional and mental wellbeing action planning had increased to 96%, representing a year-on-year improvement of approximately 10%, highlighting this as a key achievement, reflecting sustained partnership working with education partners and Local Authorities.

Ms Lewis reported that immunisation coverage remained relatively stable at around 90%, although variation between counties continued. She noted that performance has now stabilised following previous fluctuation, however, further improvement would be required to meet national targets. She also highlighted the potential impact of changes to vaccination programmes, including the introduction of the combined Measles, Mumps, Rebella (MMR) 2 vaccine and revised delivery timelines.

Ms Lewis highlighted key achievements during the year, including the successful launch of the first phase of the Population Health Dashboard, which strengthened the Health Board's ability to monitor and analyse population health outcomes. She also highlighted continued progress of multi-agency prevention work with Public Health Wales, Local Authorities and voluntary sector partners.

She also identified a number of challenges encountered during the reporting period. These included delays in digital development to support population health programmes, workforce constraints

affecting delivery capacity, and variability in public engagement and uptake across different population groups. Advising that actions had been taken to address these challenges, including recruitment to key roles, enhanced partnership working and the development of digital infrastructure to support self-management and access, Dr Gjini provided additional context to the report and emphasised that many of the programmes described formed part of longer-term, multi-year strategies. She cautioned against interpreting single-year results in isolation and stressed the importance of understanding trends over time.

Dr Gjini highlighted immunisation as a concern, noting that while access to vaccination remained critical, uptake was also influenced by behavioural and societal factors. She explained that around 80% of vaccinations were delivered through Primary Care, so delivery depends partially on GP engagement and contractual arrangements. Dr Gjini also highlighted measures to improve access, noting that targeted Health Board-led interventions, including Respiratory Syncytial Virus (RSV) clinics, had increased uptake. However, she acknowledged that overall performance remained below desired levels and required sustained effort.

Ms Marks welcomed the progress outlined in the report, however questioned whether additional action could be taken at Board and Committee level to further support the population health agenda, and ensure the work was visible and understood both internally and externally. In response, Ms Lewis highlighted the importance of strengthening communication and engagement, noting that while programmes were delivering positive outcomes, greater emphasis was needed on public awareness, community engagement and behavioural change.

Mr Maynard Davies sought assurance regarding the Health Board's understanding of population groups who were not accessing services, questioning whether sufficient data exists to enable targeted interventions and improve equity of access. Ms Lewis confirming that relevant data was available and acknowledging that further work was required to translate this into actionable intelligence, advising that the development of the Population Health Dashboard would support improved segmentation and targeting of interventions.

Mr Neil Pryor raised a broader strategic challenge regarding the extent to which the organisation was embedding a social model of health, questioning whether sufficient emphasis was being placed on prevention and community-led approaches and highlighting opportunities to engage staff more actively as health ambassadors within communities. He also explored the potential use of digital platforms and social media to influence behaviour more effectively. Mr Craig Jones highlighted the development of professionally delivered evidence-based health coaching, while recognising the value of community and digital engagement.

Mr Weir questioned whether clear indicators exist to demonstrate whether outcomes were improving over time and whether these were sufficiently visible to support Board assurance. Dr Gjini confirmed that a range of indicators existed, including measures aligned to the Board Assurance Framework (BAF) and the newly developed Population Health Dashboard, acknowledging however, that these were not yet as visible or as routinely reported as financial or performance indicators; and agreed that further work would be required to improve transparency and clarity.

Dr Bruce Bolam provided additional assurance, noting that population health metrics such as obesity rates, vaccination coverage and other determinants were routinely monitored and that long-term trends were analysed, emphasising that improvements in population health would typically be observed over longer timeframes and were influenced by a wide range of factors beyond the direct control of the Health Board.

Mr Weir challenged the use of the term “hard to reach” and suggested that the organisation should instead focus on whether services were “hard to access”. In response, Ms Lewis acknowledged this challenge and confirmed that future work would focus on improving accessibility, including expanding service availability beyond traditional hours.

Ms Alwena Hughes Moakes, highlighting the need to ensure that digital developments were aligned with the Health Board’s communication strategy and met accessibility standards, emphasising the importance of a coordinated approach to digital engagement, avoiding fragmentation and ensuring consistency of messaging.

Mr Huw Thomas, highlighting the potential role of data analytics, digital systems and artificial intelligence in improving understanding of population needs, suggested that enhanced use of patient relationship management systems could support more sophisticated segmentation and targeting, although he acknowledged that this would need to be balanced with ethical and information governance considerations.

The Committee also discussed emerging opportunities to scale prevention initiatives through alternative funding models, including social investment approaches; and noted that early discussions were underway with external partners.

Dr Gjini, acknowledging the breadth and depth of the challenges raised and reaffirming the organisation’s commitment to strengthening its population health approach, emphasised that progress required sustained focus, partnership working and cultural change across the system.

The Committee recognised that, while significant progress had been made across a number of areas, delivery of improved population health outcomes remained complex and would require

continued strategic focus. It was acknowledged that population health improvement is inherently long-term and dependent on multiple system partners.

Decision:
The Committee **RECEIVED ASSURANCE** on 2025/26 progress and the Directorate's continued commitment to improving population health and wellbeing through embedding prevention and reducing inequities into 2026/27.

SPC(26)42 **Embedding the 20four7 Prevention Model in System Delivery – Governance, Planning and Primary Care Readiness (2026/27)**

Mr Alistair Fisher joined the meeting.

Mr Alistair Fisher introduced the Embedding the 20four7 Prevention Model in System Delivery Governance, Planning and Primary Care Readiness (2026/27) report, explaining that the 20four7 Prevention Model functions as an operating framework for Hywel Dda University Health Board (HDdUHB), embedding population health and prevention across all activities through risk stratification and segmentation, and structured around four themes: leadership and governance, workforce enablement, monitoring and evaluation, and operational delivery.

Dr Gjini outlined that the model, developed over several years, is now moving into an operational phase, with 2026/27 focused on embedding prevention into routine practice, strengthening governance, enhancing workforce capability, and developing mechanisms to monitor impact.

Dr Bolam, confirming that a system-wide task group has been established to oversee implementation, with accountability embedded across executive portfolios to reflect the cross-cutting nature of prevention, highlighted workforce readiness as a key enabler, supported through training, tools and resources, including Making Every Contact Count (MECC) and cluster toolkits.

Mr Jones, describing health coaching as a central delivery mechanism, and noting strong early engagement and expansion beyond initial pilots, outlined how the approach supports behavioural change and integrates with existing services such as diabetes care, weight management and social prescribing, promoting a more coordinated model of care. This was reinforced by reference to health coaching uptake within primary care and its role in supporting prevention discussions.

The Committee considered Primary Care readiness, noting positive engagement from clusters, albeit with variable implementation across the system. It was agreed that further work is required to ensure consistency and that clusters will be critical to successful delivery.

Dr Bolam advised that monitoring arrangements are being strengthened through the Population Health Dashboard, with reporting through established governance routes. Mr Ayres confirmed that work is underway to strengthen planning capability and embed the model into annual and operational plans, ensuring clear milestones, ownership and delivery.

Mr Pryor emphasised the importance of the social model of health and community involvement, and Dr Gjini agreed that future updates on the 20four7 Prevention Model should include clear outcome measures, adoption metrics and evidence of operational delivery at scale. **AG**

Mr Weir highlighted the scale of opportunity to embed prevention across routine patient interactions and questioned whether this was being fully maximised. Mr Jones acknowledged progress, however, noted that sustained cultural change and leadership would be required to fully embed the approach.

Mr Thomas highlighted the financial context, emphasising the need to demonstrate value and explore innovative funding approaches, including social investment. Ms Lee Davies confirmed that the model is aligned with wider strategic programmes, including the CSP and Primary Care transformation.

Ms Lewis, Dr Bolam, Mr Jones and Mr Fisher left the meeting.

Decision:
The Committee:
RECEIVED ASSURANCE that the 20four7 Prevention Model:

- Is progressing from development to implementation phase; and
- Provides a coherent strategic framework for prevention delivery in 2026/27.

SPC(26)43 **Capital Programme Update**

Ms Eideg Roser joined the meeting.

Ms Eideg Rosser presented the Capital Programme Update for 2025/26, 2026/27 and the Capital Governance Update Report, highlighting the achievement of the CRL for 2025-26 with an underspend of £37,000, subject to audit. For 2026-27, an additional £500,000 from Welsh Government for mental health quality and safety was noted.

It was also noted that delivery had been closely managed throughout the year, with effective in-year monitoring enabling the organisation to conclude the financial year with only a minimal variance. Mr Weir recognised this as a significant achievement, particularly given the complexity and scale of the capital programme.

Ms Rosser outlined the key schemes included within the programme and the process by which these had been prioritised,

advising that the programme had been developed to align with strategic priorities, including the CSP, the development of community-based care models, and estate resilience requirements. However, she emphasised that the programme had been constructed within a highly constrained capital funding environment, necessitating difficult prioritisation decisions.

In response to Mr Weir's request for the principal risks, Ms Rosser confirmed that several schemes remained dependent on factors outside the Health Board's control, including land acquisition, planning approvals and external funding. She highlighted delays to the Fishguard scheme due to difficulties in securing a suitable site, with the preferred land now on the open market and negotiations ongoing. While alternative sites had been considered, these were assessed as less suitable in terms of location, accessibility and alignment with service requirements. Ms Rosser assured the Committee that work is continuing to resolve the land issue and progress commissioning plans.

Mr Maynard Davies and Mrs Marks echoed concerns regarding the Fishguard scheme and emphasised the importance of continued collaboration with Pembrokeshire County Council. The Committee also queried contingency planning, with Ms Rosser confirming that alternative options had been explored and engagement with partners, including Local Authorities and NHS Wales Shared Services Partnership (NWSWSP), remains ongoing, although some risks will persist due to external dependencies.

Members also noted that the opening of the Atriwm (formerly Carmarthen Hwb) is expected to be delayed due to additional external infrastructure works, with handover now anticipated in the final quarter of 2026 and opening projected for January 2027.

In relation to cost pressures within the capital programme, the Committee noted that several schemes were at risk of cost escalation due to market conditions, inflation and changes in scope. Mr Thomas provided financial context, advising that construction inflation and supply chain constraints continued to present significant challenges He emphasised that, although robust cost management and risk mitigation measures were in place, these risks could not be fully eliminated.

The Committee sought assurance regarding the robustness of the prioritisation process, given the limited availability of capital funding. Ms Rosser, confirming that a structured prioritisation framework had been applied, acknowledged that the constrained funding envelope meant that not all desirable schemes could be progressed within the immediate programme.

Ms Wilson outlined the framework for oversight of the capital programme, including the role of the Capital Sub-Committee (CSC) and the reporting lines into the SPC and the Board. She advised that enhanced governance arrangements had been

developed to strengthen oversight, improve risk management and ensure transparency.

The Committee welcomed the strengthened governance arrangements, however challenged whether reporting provided sufficient visibility of key risks and dependencies. Mr Weir emphasised the importance of ensuring that both current and emerging risks were clearly articulated, particularly where delay or failure to deliver could have wider strategic implications.

Mr Carruthers, highlighting the need to align capital planning with service transformation, and noting that capital schemes should not be considered in isolation but as enablers of broader service change, emphasised that the integration of capital planning with clinical strategy, workforce planning and digital development would be critical to delivering sustainable transformation.

The Committee considered alternative funding models and the potential to supplement traditional capital allocations; and Mr Thomas outlined a range of potential approaches, including mutual investment models, leasing arrangements and partnership-based developments, cautioning that while such approaches could unlock additional capital investment, they would have long-term revenue implications and would require careful consideration in the context of the Health Board's financial position.

The Committee considered whether greater emphasis could be placed on collaboration with external partners, including Local Authorities, housing associations and private sector organisations, to support delivery of capital schemes. Mr Lee Davies confirmed that partnership approaches were actively being explored and that these would form an increasingly important component of the capital strategy.

The Committee also reviewed the position in relation to targeted capital investments and infrastructure resilience. Ms Rosser highlighted key investments in areas such as energy resilience and estate maintenance, noting that these were essential to ensure the safe and effective operation of services. Members acknowledged the importance of balancing investment in strategic developments with the need to maintain existing infrastructure. The Committee noted the significant constraints affecting delivery of the capital programme. It recognised the challenge for the Health Board in balancing the need to maintain existing infrastructure, progress strategic transformation and operate within a limited financial envelope.

Mr Weir noted that the programme remained aligned with the Health Board's strategic priorities and that risks were being actively managed, although delivery of the programme would continue to require careful management and ongoing review.

Decision:
The Committee:

- **RECEIVED ASSURANCE** from the update on the Capital Programme and CRL for 2025/26
- **NOTED** the Board endorsed allocation of the DCP for 2026/27
- **RECEIVED ASSURANCE AND WILL UPDATE THE BOARD**, that the seal can be applied for all schemes listed in Annex 1
- **RECEIVED ASSURANCE** from the capital schemes governance update
- **RECEIVED ASSURANCE** from the Capital Sub Committee update in Annex 2 and the 2025/26 Annual Report in Annex 3

SPC(26)44 **Targeted Estates Fund (TEF) Project: Provision of Second Generator at Prince Philip Hospital**

Mr Simon Chiffi and Mr Julian Wheeler Jones joined the meeting.

Mr Julian Wheeler Jones presented the Targeted Estates Fund (TEF) Project: Provision of Second Generator at Prince Philip Hospital report, indicating that the project formed part of the Health Board's wider estates resilience programme; and highlighting that reliable infrastructure, including uninterrupted power supply, was fundamental to the safe operation of clinical services, particularly within acute hospital settings. The proposal therefore aimed to strengthen resilience, mitigate risk and ensure continuity of patient care in the event of power disruption.

Mr Wheeler Jones, advising that the existing generator provision at Prince Philip Hospital (PPH) was currently insufficient to provide full resilience across all critical services, indicated that while the existing infrastructure met minimum requirements, it did not provide adequate redundancy in the event of system failure, planned maintenance or prolonged outages. The installation of a second generator would therefore create a dual-redundancy system, significantly reducing the risk of service interruption.

The Committee noted that the proposal had been developed following technical assessment and risk appraisal, which had identified the current single-generator configuration as a key vulnerability within the estate. This risk was particularly significant given the increasing reliance on electrically powered clinical equipment, digital systems and infrastructure.

Mr Wheeler Jones outlined the financial position, confirming that the total project cost had been estimated at £1.197m. It was explained that funding would be sourced through the Welsh Government Targeted Estates Fund (TEF), supplemented by a required contribution from the Health Board. The Committee noted that the TEF funding represented a 70% contribution, with the remaining 30% to be met locally.

Mr Weir sought assurance regarding the robustness of the cost estimates and procurement arrangements; and Mr Wheeler Jones confirmed that the project had been subject to appropriate

procurement processes, with the preferred contractor identified through competitive tendering. It was explained that cost estimates included contingency allowances to mitigate risks associated with construction, installation and commissioning. The Committee questioned whether the contingency level was sufficient, particularly in the context of recent market volatility and cost inflation within construction and engineering sectors. In response. Ms Rosser advised that benchmarking had been undertaken against similar schemes and that the contingency provision was considered proportionate to the level of risk identified. However, it was acknowledged that residual risk remained, and this would be actively managed through project governance arrangements.

In response to Mr Weir's enquiry regarding whether the project had been appropriately prioritised within the overall capital programme, and noting the constrained financial environment and competing demands, Ms Rosser confirmed that the scheme had been prioritised based on risk, with resilience of critical infrastructure identified as a key strategic priority. It was emphasised that failure to address this risk could have significant implications for patient safety, operational continuity and regulatory compliance.

Further discussion focused on the operational implications of not proceeding with the project. Mr Wheeler Jones advised that reliance on a single generator created exposure to service failure in the event of equipment malfunction or maintenance requirements, which could lead to disruption of critical services, including theatres, diagnostic equipment and digital systems. The Committee acknowledged the potential severity of such risks and recognised the importance of proactive mitigation.

The Committee also explored the integration of this project with wider estates and capital planning; and it was confirmed that the scheme formed part of a broader programme of infrastructure investment, including energy resilience, backlog maintenance and estate modernisation. It was emphasised that such investments, although not always visible to patients directly, were essential to underpin safe and effective service delivery.

Mr Thomas provided additional financial context, noting that while the TEF funding supported a significant proportion of the scheme, the requirement for local contribution must be considered alongside competing financial pressures. He emphasised the need to balance investment in infrastructure with the broader financial position of the Health Board while acknowledging that investment in resilience represented a necessary and unavoidable cost.

Ms Rosser confirmed that the scheme would be managed through established capital governance processes, including oversight by the CSC and regular reporting on progress, risk and financial performance. It was further confirmed that key milestones,

including installation and commissioning, would be subject to formal review to ensure compliance with technical and safety standards.

The Committee discussed the potential for disruption during installation and sought assurance that risks to service delivery had been considered. Assurance was received that detailed planning had been undertaken to minimise disruption, including phasing of works and coordination with clinical teams.

Ms Eldeg Rosser, Mr Simon Chiffi and Mr Julian Wheeler Jones left the meeting.

Decision:
The Committee:

- **RECOMMENDED** for onward ratification by Board on 28 May 2026 award of the contract at £1,197,665.00 (exc. VAT) for Prince Philip Hospital to 'T. Richard Jones (Fetws) Ltd', with call-off agreement to be prepared and executed by the Health Board

SPC(26)45 A Healthier Mid and West Wales Strategy Update

Mr Nathan Davies joined the meeting.

Mr Lee Davies presented the AHMWW - Healthier Lives, Well Lived Strategy Update report, advising that the Strategy had reached an advanced stage of development and was being prepared for submission to the Board for formal approval. He emphasised that the Strategy represented a significant piece of work for the organisation, forming the overarching long-term framework for service transformation, population health improvement and partnership working across the region over a projected fourteen-year period.

Ms Hughes Moakes advised that a key focus during the final stage of development had been to ensure that the Strategy was accessible, inclusive and relevant to a wide range of stakeholders. In addition to the full strategic document, a suite of supporting materials had been produced, including simplified summaries, youth-focused versions, easy-read formats, audio outputs and alternative accessible formats such as British Sign Language translations. She emphasised that this approach was designed to enable meaningful engagement with communities.,

Further, Ms Hughes Moakes, confirmed that engagement had been undertaken with a wide range of stakeholders, including patients, communities, staff, partners and third sector organisations, emphasising that feedback from this engagement had directly influenced the development of the Strategy, including the prioritisation of themes and the emphasis placed on prevention, community-based care and reducing inequalities.

Mr Weir, welcoming the progress made and emphasising the importance of ensuring that the Strategy was not only

comprehensive in scope but also understood and owned by the population it was intended to serve, challenged Members to ensure that the Strategy translated into practical changes that would be visible and meaningful to patients and communities.

The Committee considered the extent to which the Strategy aligned with other key programmes, including the CSP, the 20four7 Prevention Model and the development of integrated care systems. Mr Lee Davies confirmed that alignment had been a core principle throughout the Strategy's development, with deliberate effort made to ensure consistency across programmes and to avoid duplication or fragmentation.

The Committee, considering the challenge of implementation, emphasised that while the development of a comprehensive Strategy was important, the critical measure of success would be the ability to deliver the planned changes. There was recognition that the scale and ambition of the Strategy would require sustained commitment, significant cultural change and effective coordination across multiple organisations.

In response, Mr Lee Davies acknowledged the importance of implementation and advised that work was underway to develop detailed delivery plans and governance arrangements to support the next phase. He confirmed that the Strategy would be supported by a structured implementation framework, with clear accountability and monitoring arrangements.

Mr Weir highlighted the need for clear, measurable outcomes that would enable the Board and Committee to determine whether the Strategy would achieve its intended impact. In response, Mr Lee Davies advised that outcome measures would be aligned to existing frameworks, including the BAF and population health indicators, and that further work was being undertaken to refine these measures.

Mr Lee Davies, confirming that the Strategy had been designed with flexibility in mind and would be subject to regular review and refresh to ensure that it remained relevant and effective, advised that governance arrangements would include mechanisms for ongoing review, enabling the organisation to respond to emerging challenges and opportunities.

The Committee emphasised the importance of collaboration with Local Authorities, Primary Care, regional partners and the third sector, noted the Health Board's stance that partnership working was central to the Strategy and that delivery would be dependent on effective collaboration across the system.

The Committee reflected on the strategic significance of the programme, recognising that it provided the overarching framework within which many of the Health Board's key initiatives would sit, while Mr Weir emphasised that the Committee's

ongoing role would be to provide assurance that the Strategy was being implemented effectively and delivering its intended benefits.

Mr Nathan Davies left the meeting.

Decision:
The Committee:

- **NOTED** and **RECEIVED ASSURANCE** from the update provided in the A Healthier Mid and West Wales - Healthier Lives, Well Lived Strategy Update report.

SPC(26)46 Annual Plan 2025-26 Closure Report

Mr Dan Warm joined the meeting.

Mr Ayres presented the Annual Plan 2025-26 Closure Report, emphasising that the report should be considered not only as a retrospective review but also as a foundation for the 2026–27 annual planning process. He advised that the report demonstrated measurable progress across several key areas, while also highlighting persistent challenges and opportunities for improvement.

In providing an overview of performance against headline objectives, Mr Ayres reported that notable improvements had been achieved in cancer performance, with delivery improving against the national target, although it remained below the required standard. He also highlighted improvements in Urgent and Emergency Care pathways, alongside progress in mental health and long-term condition management, noting that these areas had been successfully de-escalated within the Welsh Government Targeted Intervention (TI) framework.

In response to Mr Weir's request for clarification on the extent to which these gains were sustainable and what mechanisms were in place to ensure continued progress, Mr Ayres indicated that while improvements had been achieved, they remained fragile and required ongoing focus, particularly given competing pressures across the system. He emphasised that sustained improvement would depend on embedding changes within operational delivery models and ensuring alignment with workforce and financial planning.

Mr Ayres highlighted theatre utilisation as a particular concern, noting that late starts and early finishes continued to impact productivity and efficiency, advising that internal analysis had identified significant variation in performance and that there was substantial potential to improve throughput through better operational discipline and management.

The Committee challenged the scale of the issue and sought clarity regarding the underlying causes. It was noted that inefficiencies were not solely attributable to individual behaviours but also reflected systemic issues, including scheduling, workforce availability and clinical pathway design. Mr Weir emphasised the

need for a holistic response rather than solely focusing on operational performance metrics.

Mr Maynard Davies noted that early finishes were significantly above expected levels and represented a clear opportunity for improvement. He also observed that, overall green-rated areas had been delivered and amber-rated were generally progressing as expected, indicating a broadly positive trajectory, albeit with some areas requiring targeted intervention.

Mr Michael Imperato raised a broader question regarding the interface between this Committee and the Finance and Performance Committee (FPC). He sought clarification on where responsibility for addressing productivity and performance issues should sit and whether there was a risk of duplication or fragmentation in oversight.

In response, Mr Ayres acknowledging that there was inherent overlap between strategic planning and performance management, and emphasising that this Committee's primary role was to ensure that credible, integrated plans existed that would enable delivery, noting that the detailed monitoring of performance metrics would be more appropriately considered within the FPC, but that strategic alignment and planning remained the responsibility of this Committee.

Mr Thomas emphasised that the focus should not be only on increasing activity, but on using resources to maximise value and improved patient outcomes. He highlighted high-value interventions, such as fracture liaison services, and opportunities to expand them, while emphasising the importance of reducing low-value activity. He noted that this work would be taken forward through the FPC, aligned with strategic planning.

The Committee noted that current reporting was fragmented and supported a more integrated approach combining financial, workforce, activity and quality information. Mr Ayres confirmed that future Board reporting would be aligned to provide a clearer picture of how delivery of the Annual Plan translates into financial and operational outcomes.

Mr Ayres indicating that, while some risks had been mitigated during the year, others had emerged or increased in significance, emphasised that this reflected the dynamic nature of the operating environment and the scale of transformation being undertaken. Ms Wilson provided further context, explaining that changes in the risk profile were expected and that movements reflected both progress in some areas and emerging challenges in others. She suggested that a mapping exercise could be undertaken to provide greater clarity on how risks had evolved over the course of the year and to support improved assurance to the Board. **JW**

The Committee supported this proposal and emphasised the importance of ensuring that risks were clearly articulated and aligned to strategic priorities.

The Committee also discussed the relationship between the Annual Plan and longer-term strategic planning. Mr Dan Warm highlighted that delivery in 2025 - 26 provided a baseline for 2026 - 27 and that there was continuity between Annual Plans and longer-term programmes such as the CSP and the Community by Design Strategic Plan (formerly the Primary and Community Care Strategy). He emphasised that progress achieved during the year should be viewed as part of an ongoing trajectory rather than as isolated outcomes.

The Committee acknowledged that the requirement to deliver significant savings within a constrained funding environment created tension between achieving financial balance and maintaining or improving performance. This was recognised as a fundamental challenge that would continue to impact delivery in future years.

The Committee noted that lessons learned had been incorporated into planning processes for 2026 - 27 and that a more structured approach to delivery planning, including clearer milestones and accountability, would be adopted. The Committee, highlighted opportunities for improvement, particularly in relation to productivity, pathway redesign and integration of services, emphasising the importance of ensuring that these opportunities were actively pursued and translated into tangible improvements in delivery.

Mr Shaun Ayres and Mr Dan Warm left the meeting.

Decision:
The Committee:

- **RECEIVED ASSURANCE** on the update on the 2025/26 Annual Plan with specific reference to the Planning Objectives aligned to the Committee and the 2025/26 Enabling Actions.

SPC(26)47 Clinical Services Plan

Mr Alex Martin joined the meeting.

Mr Alex Martin presented the CSP, outlining the future configuration of services to ensure sustainability, improved outcomes and alignment with population needs; and confirming that the programme had now moved beyond strategy development and into a phase focused on translating agreed principles and decisions into implementable delivery plans.

Mr Martin indicated that the Board had previously agreed a series of high-level decisions regarding the direction of travel for key services, including the principles of centralisation, networked care and the strengthening of community provision. The current phase

of the programme was therefore focused on operationalising those decisions, including defining detailed pathways, workforce implications, infrastructure requirements and engagement plans.

The Committee noted that while the overarching direction of travel had been endorsed, there remained areas where definitive service models had not yet been finalised. Particular attention was given to stroke services, which had been subject to ongoing engagement and development.

In response to Mr Weir's request for assurance regarding progress on Stroke services, Mr Martin confirmed that work was progressing in line with expectations, with further clinical and stakeholder engagement planned to inform the final model. He emphasised that the approach remained consistent with the strategic direction agreed by the Board and that no deviation from that direction was anticipated.

Mr Lee Davies advised that the programme remained on track from a process perspective and that it was appropriate to allow sufficient time for robust engagement and evidence gathering, particularly for complex service areas such as Stroke. It was emphasised that assurance at this stage related to the robustness of the process rather than the finality of outcomes.

The Committee considered the broader issue of implementation planning, noting that successful delivery of the CSP would require a high degree of integration across multiple domains, including finance, workforce, capital and digital. Mr Weir emphasised that without clear alignment across these enabling strategies, there was a risk that the programme would not be deliverable in practice.

In response, Mr Martin confirmed that work was underway to ensure integrated planning across all enabling domains. This included the development of detailed delivery plans setting out milestones, dependencies and resource requirements. It was acknowledged, however, that further work was required to achieve the level of granularity expected, particularly in light of feedback received from Welsh Government regarding planning maturity.

Mr Ayres reinforced this point, noting that one of the key challenges facing the organisation was the need to translate high-level strategic intent into clear, executable plans with defined accountability and timelines; and emphasising that improving planning maturity would be critical to successful implementation of the CSP.

The Committee considered the relationship between the CSP and other strategic programmes, including AHMWW Strategy and the 20four7 Prevention Model. Mr Lee Davies confirmed that alignment across these programmes had been a key consideration throughout development and that the CSP was

intended to operate as a central component within a wider system of strategic plans.

Mr Martin confirmed that implementation would be phased over a number of years, reflecting the scale of transformation and resource constraints. Initial delivery would focus on changes achievable within existing resources, with more complex or resource-intensive changes planned for later phases.

Mr Maynard Davies questioned whether the timeline for delivery was sufficiently ambitious, noting the urgency of addressing current service pressures. Mr Lee Davies acknowledged this challenge but emphasised that realism was required in planning, particularly given workforce limitations, financial constraints and the need to maintain safe service delivery during transition.

. Mr Weir highlighted the importance of maintaining public and stakeholder confidence throughout the transformation process, emphasising that transparent communication and clear articulation of benefits would be essential to securing support for change.

The Committee highlighted the need for regular, structured updates that clearly demonstrated progress against milestones, risks to delivery and alignment with enabling strategies; and Ms Wilson noted that reporting arrangements would need to be aligned with governance requirements and that the Committee's role in providing oversight of strategic planning should be clearly defined.

Mr Martin, reiterating that the programme remained in its pre-implementation phase and that the focus over the coming months would be on strengthening delivery plans, confirming resource requirements and progressing engagement activity, advised that a further update, including more detailed implementation timelines, would be presented to the Committee and Board in due course.

Mr Alex Martin left the meeting.

Decision:
The Committee:

- **RECEIVED ASSURANCE** that work is being undertaken to develop a detailed implementation plan for the eight services which received a final decision
- **RECEIVED ASSURANCE** that work is being undertaken to carry out the engagement on stroke services, to support Board to make a final decision within this planning year 2026/2027

SPC(26)48 DEFERRED: Value Based Healthcare Update

SPC(26)49 Joint Commissioning Committee Planning, Performance and Finance Sub-Committee Reports

The Committee **NOTED** the Joint Commissioning Committee Planning, Performance and Finance Sub-Committee Reports.

SPC(26)50 Strategy & Planning Committee Workplan 2026-27

The Committee **NOTED** the Strategy & Planning Committee Workplan 2026-27

SPC(26)51 Any Other Business

None.

SPC(26)52 Date and Time of Next Meeting

Thursday 25 June 2026, 09:00 - 12:30, HDD Picton - Dolau Cothi & MS Teams

Thursday 20 August 2026,
Monday 2 November 2026,
Tuesday, 22 December 2026,
Tuesday, 2 March 2027.