Escalation update

August 2026

Criteria 5 to 9: Strategy and Planning

Committee meeting: Thursday 20 August 2026

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Executive summary: no criterion supports de-escalation; Criterion 8 moves to Alert

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Since June 2026 the position has hardened. Welsh Government (WG) has confirmed the 2026/27 Annual Plan is not accepted, and the planning maturity review has fallen behind the timetable we set for it.

- The escalation framework is how WG assures itself that a Health Board is planning properly: Criteria 5 to 9 test the quality of our planning rather than the safety of the care we deliver day to day. Alert means the evidence does not yet meet the standard required to step down a level.

WHAT HAS CHANGED SINCE JUNE 2026

- WG wrote on 23 July 2026 that the Plan remains unacceptable and unsupportable, that the statutory planning and financial requirements have not been met, and that we do not have an agreed or supported plan. The de-escalation criterion for a credible plan is not met.
- The de-risking work reported in June 2026 has produced outputs: a financial roadmap prepared and discussed with WG, strengthened savings identification, and a planned care plan scheduled for Board approval by 31 July 2026. Outputs have not yet changed the assessed position.
- The Clinical Services Plan (CSP) completed its phased implementation assessment. The stroke consultation completes its eight week period on 26 July 2026; the route to a November 2026 decision holds.
- The planning maturity return drew ten responses from the Planning Steering Group, materially below the level anticipated. Executive and Independent Member scoring has not started, and Board sign off will not be achieved by 31 July 2026 as planned.

RECOMMENDED POSITIONS

Criterion 5 Alert, no change. Criterion 6 Advise, no change. Criterion 7 Assure with a watch on pace, no change. Criterion 8 Alert, moved from Advise. Criterion 9 Alert, no change. **No criterion meets the evidential threshold for de-escalation this cycle.**

Welsh Government's assessment is explicit: the plan is not agreed and confidence is not secured

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The 12 June 2026 letter set three actions; the 23 July 2026 letter confirms the plan remains unacceptable while that work is delivered:

- **12 June 2026, after Escalation Board on 3 June 2026:** the Health Board did not demonstrate sufficient grip on its financial and performance challenges. Three actions were set: a financial roadmap and route to balance; a 50% reduction in nationally reportable incident investigations; and ambitious trajectories for planned care, cancer and urgent and emergency care (UEC). Our consolidated return was prepared for the 24 July 2026 deadline, ahead of the Escalation Board on 4 August 2026.
- **23 July 2026, on the Annual Plan:** the Plan 'continues to be unsupportable and unacceptable'. The Health Board has 'failed to meet the statutory planning and financial requirements,' has not met 'the de-escalation criteria for a credible annual plan,' and 'does not have an agreed or supported plan.' The immediate priority set for us is to de-risk and improve the in-year performance and financial positions, alongside a Financial Recovery Plan to balance.
- **April 2026, Chairs' objectives from the Cabinet Secretary:** deliver the Planning Framework expectations; implement the CSP once agreed and resolve temporary service changes; and agree four key deliverables with Swansea Bay University Health Board (SBUHB) through the Joint Regional Committee (JRC) that demonstrate improved patient outcomes.
- **30 June and 1 July 2026, national planned care letters:** waits over 104 weeks to be eliminated and diagnostic waits capped at eight weeks, with funding conditional on evidenced delivery. Delivery detail sits with the Finance and Performance Committee (FPC); the planning consequence is that our submitted trajectories sit below the strengthened national requirements.

What this means: this correspondence is the standard against which Criteria 5 and 8 are assessed. Acceptance is withheld and confidence is not secured; our response must evidence delivery rather than restate process.

Criteria 5 to 9 at a glance: three Alert, one Advise, one Assure

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The ratings apply the WG de-escalation criteria and weigh evidence in the order process, output, outcome, impact. Positions are stated as at 24 July 2026.

Criterion	June position	Position at 24 July 2026	Direction of travel	Recommended status
5. Submission of an acceptable annual plan	Alert	Plan formally not accepted; statutory breach stated on 23 July 2026; de-risking outputs delivered but the £41.0m forecast is unchanged	No improvement	**Alert (maintain)**
6. Integrated planning supporting a coherent, deliverable plan	Advise	Integration more visible in the Plan, the joint Board report and escalation evidence; delivery not yet consistent at Month 3	Improving slowly	**Advise (maintain)**
7. Clear roadmap and implementation of the Clinical Services Plan	Assure	Phased assessment complete; analyse stage active; no business case started; stroke consultation on track for a November 2026 decision	On roadmap; pace is the risk	**Assure (maintain, watch pace)**
8. Welsh Government confidence in delivery (planning maturity matrix)	Advise (could be Alert)	Maturity review behind its timetable; ten responses, none with evidence attached; executive scoring not started; 23 July 2026 letter states confidence is not secured	Deteriorated	**Alert (move from Advise)**
9. Progress with regional planning (orthopaedics, ophthalmology, stroke, urology, upper GI)	Alert	Four regional deliverables now set as the test by the Cabinet Secretary; orthopaedic long term agreements still unresolved; delivery still not evidenced	No evidenced change	**Alert (maintain)**

Criterion 5: Welsh Government has not accepted the Annual Plan

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Required outcome: submission of an acceptable Annual Plan in line with the planning framework.

Reported in June 2026: Alert. The plan was submitted with a £41.0m planned deficit against a £22.1m control total and was acceptable to neither the Board nor WG. We committed to use Quarter 1 de-risking to validate commitments and to evidence a credible route towards the control total.

WHAT THE EVIDENCE NOW SHOWS

- WG confirmed on 23 July 2026 that the Plan remains unacceptable and unsupportable, that the statutory planning and financial requirements have not been met, and that we do not have an agreed or supported plan. This formalises the position; it does not change it.
- De-risking has produced outputs: a financial roadmap prepared and discussed with WG, with presentation the refreshed route map scheduled for the Board meeting on 24 September 2026; savings identification management reported at £21.0m of the £42.8m requirement at 23 July 2026, with further opportunity, subject to Executive sign off; and a planned care plan scheduled for Committee approval by 31 July 2026. Financial delivery is owned/overseen by the FPC.
- The forecast deficit is unchanged at £41.0m, and WG notes no assurance yet on delivery of the planned underlying deficit position for March 2027.

What this means: the criterion tests acceptance, and acceptance has been explicitly withheld. The evidence has strengthened at output level only; the outcome has not changed.

Assessment: **Alert, no change.** Direction of travel: no improvement; the risk position is now formally stated.

Criterion 6: integrated planning is better evidenced, but delivery is not yet consistent

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Required outcome: evidence of integrated planning across the organisation supporting a coherent and deliverable Annual Plan.

Reported in June 2026: Advise. The integrated model was established on paper; the gap was consistent deliverability. We committed to strengthen the link between planning assumptions and delivery confidence and to recruit dedicated planning capacity into the Clinical Care Groups (CCGs).

WHAT THE EVIDENCE NOW SHOWS

- The Board meeting on 30 July 2026 was asked to approve three Band 8C heads of planning and improvement, embedded in the CCGs at a recurrent cost of £310,971, half funded centrally through an explicit non-pay to pay conversion. This converts the June 2026 commitment into permanent planning capacity. This has now been approved and final undertaking from the CCGs for their 50% is the only remaining action.
- Planning, finance and performance evidence is now assembled as one read-across. The joint Annual Plan report for the 30 July 2026 Board meting ties the Month 3 position, the financial forecast, Integrated Performance Report and escalation status into a single assessment, and the Escalation Board evidence pack is built on the same baseline.
- Delivery remains uneven. Month 3 shows the Plan is not yet delivering the required improvement consistently, and savings delivery in parts of the organisation is subject to internal escalation. The performance detail is owned by the FPC; the planning implication is that assumptions and delivery have not yet converged.

What this means: integration is increasingly visible in how we plan within some elements of the Health Board as evidenced in the above report. The evidence remains process and output; however, there is still a gap around plans that drive consistent delivery and is the outstanding test, and it is the test WG has set.

Assessment: **Advise, no change.** Direction of travel: capability improving (subject to ratification of the planning roles); delivery not yet consistent.

Criterion 7: the CSP roadmap holds; the test has moved to implementation

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8 of 9
services with decisions confirmed at the February 2026 Extraordinary Board

7
service changes in delivery during 2026/27, led by workforce rather than capital

7
components needing capital, through WG business planning

0
business cases started; the design stage opens when current assessments conclude

Define
Complete: February 2026 decisions

Measure
Complete: phased assessment

Analyse
Active: detailed assessments

Design
Not started: business cases

Verify and deliver
Not started: approvals

Service	Change in delivery during 2026/27	Key dependency and response	W	E	S
Critical care	Enhanced care unit at Prince Philip Hospital (PPH)	Interim standard operating procedure not yet agreed; task and finish group defining workforce requirements	A	G	R
Endoscopy	Additional capacity at Glangwili Hospital (GGH)	Nurse and endoscopist recruitment per the Annual Plan; space depends on urology vacating	A	A	A
Emergency general surgery	Progress towards a single emergency rota at GGH	Recruitment under way; rota changes consulted early with medical teams; supports a one in 12 end state	A	G	A
Orthopaedics	Theatre and procedure basket optimisation at Withybush Hospital (WGH)	Anaesthetic, theatre and day surgery capacity needed to support increased activity	A	G	G
Radiology	Withdrawal of the x-ray service at Llandovery	Contractual changes to be considered; patients travel to alternative sites	A	G	G
Radiology	Withdrawal of the x-ray service at South Pembrokeshire	Minimal workforce impact expected; patients travel to alternative sites	G	G	G
Urology	Phased migration of outpatient activity to PPH	Workforce subject to funding confirmation; constrained until suitable space is available	A	A	G

Ratings are the programme's phased assessment of workforce (W), estates (E) and safety (S): green deliverable; amber deliverable with unknowns; red dependencies and risk not yet mitigated. Capital components (dermatology unit, urological investigations unit, endoscopy accreditation and capacity, surgical same day emergency care at Bronglais, orthopaedic space at Bronglais, ophthalmology co-location at Glangwili, regional diagnostic radiology hub) have no implementation dates until Welsh Government business planning concludes.

Assessment: **Assure on the roadmap, no change, with pace now the material risk: no business case has started and the June commitment to a strategic response on wider service fragility remains outstanding.**

Criterion 7: the stroke consultation is in its final days; the November 2026 decision route holds

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The proposal under consultation: a 24 hour acute stroke unit at GGH, with acute stroke rehabilitation at Bronglais Hospital (BGH).
A merged option combining elements of two alternatives generated by our communities, because none of the four original options fully addressed what people told us.

Solid markers are complete; open markers are scheduled. Position as at 24 July 2026.

Assurance step	What it told us	How we are responding
Pre consultation quality assurance, Stages 1 to 4 complete before launch	The consultation follows best practice, can be understood, contains the information people need and seeks views without bias	Independent advice continues through the consultation quality assurance framework; assurance letters appended to the Board report
Mid point review, 29 June 2026, with Llais	Independent Member and clinical attendance are positive; concerns centre on travel and transport, care closer to home and the treat and transfer model; Llais heard the same themes	Template responses reported in full, not only coded; Welsh Ambulance Services University NHS Trust (WAST) views incorporated in the closing report; continued work with community groups to correct misconceptions

Decision route. The 30 July 2026 Board meeting was asked to note consultation activity, take assurance on the quality assurance process, and decide whether to confirm reporting to the November 2026 Board. Findings go to a Board Seminar in October 2026, with the decision at the Board meeting on 26 November 2026 . This was accepted by the Board;.

Assessment: this evidence supports the criterion 7 Assure rating.

Criterion 8: Maturity Matrix WG confidence is not secured; we recommend Alert

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Required outcome: WG confidence in delivery, assessed against the planning Maturity Matrix, with a minimum expectation of Level 3 in each of the six domains.

Reported in June 2026: Advise, could be Alert, constrained by Criterion 5. We committed to a strengthened, evidence led review on a stated timetable: return issued in June 2026, calibration and Executive review in July, Board sign off by 31 July 2026, submission to WG in early August 2026.

WHAT THE EVIDENCE NOW SHOWS

- The return was issued in June 2026 as planned. The response was materially below the level anticipated: ten responses between 12 June and 16 July 2026, none attaching supporting evidence, and Executive and Independent Member scoring has not begun (due to awaiting more responses). Board sign off by 31 July 2026 will not be achieved and the submission date must be reset.
- WG's 23 July 2026 letter states we have 'not provided the assurance or levels of confidence required.' Confidence in delivery is precisely what this criterion measures, and the letter is the most recent statement of it.
- The criterion is integrative and cannot be rated above its weakest critical dependency; Criterion 5 remains at Alert. In June that constraint was the main argument. The criterion's own evidence has now weakened: the exercise designed to demonstrate maturity is running late, on a thin and unevidenced response base.

What this means: a rating held at Advise would now rest on intent rather than evidence.

Assessment: **Alert, moved from Advise.** Direction of travel: deteriorated since June 2026.
The Committee is asked to **endorse the revised rating and the reset timetable on the next slide.**

Criterion 8: the maturity return is incomplete, and the submission timetable has been reset

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What the return shows at 24 July 2026. Ten responses were received between 12 June and 16 July 2026, against a considerably larger Planning Steering Group membership, and none attached supporting evidence. The response base is therefore too small, and too unevenly spread across corporate and clinical areas, to support a validated organisational score.

PROVISIONAL OBSERVATIONS, NOT FINDINGS

- On mean scores, no theme reaches the Level 3 minimum. The weakest themes are the technical planning disciplines: Integrated Medium Term Plan (IMTP) development (scored at Level 1 by every respondent), alignment between the clinical services strategic plan and the Plan (1.3), and demand and capacity modelling (1.4). Demand and capacity modelling and benchmarking are the most frequently cited improvement priorities in the returns.
- Relational and governance themes score relatively stronger: strategy and planning (2.9), governance (2.8), engagement in development (2.8) and clinical leadership (2.7). If the pattern holds, it repeats WG's January 2026 feedback: stronger on process and relationships than on the technical disciplines that make plans deliverable.
- No respondent attached supporting evidence, which is the specific weakness the redesigned method was built to address. Attached evidence would represent a gold standard return; in its absence, several respondents set out clear reasons alongside their scores, and that narrative has been retained. These remain early observations from a small and unvalidated return. Executive and Independent Member scoring, calibration and evidence testing have not taken place, and the observations must not be read as organisational findings.
- The Maturity Matrix feedback will shape the 2027/28 planning round and is the main input into how that process is developed. Understanding the views of the wider organisation allows us to build on strengths and address weaknesses in the same exercise.

ACTIONS AND RESET TIMETABLE

Direct follow up has been undertaken and the response window extended. Calibration and Executive and Independent Member scoring move to August 2026, and Board sign off moves beyond 31 July 2026. The 2025 national cycle required Board approved returns by 28 November; the 2026 deadline should be confirmed with WG so that the reset lands inside it.

The implication: the level of engagement with this exercise is itself a measure of planning maturity and visibility, and WG reads it that way.

Criterion 9: regional planning is active, but we still cannot evidence delivery

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Required outcome: progress with regional planning across orthopaedics, ophthalmology, stroke, urology and upper gastrointestinal services.

Reported in June 2026: Alert, moved from Advise, because expectations and delivery were not hanging together. The Committee required a specialty by specialty recovery position, including resolution of the orthopaedic financial and contractual framework.

WHAT THE EVIDENCE NOW SHOWS

- The Cabinet Secretary's objectives letter makes the regional test explicit for 2026/27: agree four key deliverables with SBUHB through the JRC that demonstrate improved patient outcomes. That is now the standard this criterion will be assessed against, and the deliverables have not yet been agreed.
- The long term agreements for elective orthopaedics remain unresolved, and delivery to date remains proof of concept. The specialty by specialty recovery position required in June 2026 has not yet been evidenced to this Committee.
- There is regional content in year: the planned care plan includes purchased regional orthopaedic capacity, stroke is our most advanced regional programme with a November 2026 decision route, and the national planned care letters make regional collaboration a condition of additional funding. Activity is not the gap; evidenced delivery is.
- Joint working has improved around the planned care returns and the regional gap in several specialties. This is early alignment rather than evidenced delivery , but it is a positive change since June 2026.

What this means: until the financial and contractual framework is agreed and the four deliverables are set with owners and dates, we cannot evidence progress at the standard the criterion requires.

Assessment: **Alert, no change.** Direction of travel: no evidenced change since June.

Cross-cutting: ownership, evidence depth and milestone discipline recur across the criteria

Three patterns appear across more than one criterion. Each is a planning maturity signal, and together they explain why the ratings sit where they do.

- **Ownership and engagement.** The maturity return drew ten responses, and savings delivery in parts of the organisation is subject to internal escalation. The heads of planning and improvement investment is the structural response, and it now needs to be seen to change engagement. The wider Planning Steering Group remains central, because its members will co-ordinate and drive the 2027/28 annual planning process.
- **Evidence stops at output.** Across all five criteria we can evidence process and product: a submitted Plan, a completed phased assessment, a launched consultation, an issued return. Outcome and impact evidence remains thin, and that distinction is now the explicit language of WG's assessment of us.

What this means: the criteria will move when we present evidence of delivery rather than description of intent. That is the standard this report has applied to its own assessment.

Recommendation to the Committee

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The Committee is asked to:

- **RECEIVE ASSURANCE** from the assessment and supporting evidence that Criteria 5 and 9 remain at Alert, Criterion 6 at Advise, Criterion 7 at Assure with a watch on pace, and Criterion 8 moves from Advise to Alert. No criterion meets the evidential threshold for de-escalation this cycle.
- **SCRUTINISE** the maturity reset and confirm the revised timetable for calibration, Executive and Independent Member scoring, Board sign off and submission to WG, and the actions to lift the response base, so the reset is a Committee decision rather than a slipped deadline.