Strategy and Planning Committee

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Targeted intervention escalation update

June 2026

Criteria 5 to 9: planning

Lead executive: Mr Lee Davies, Director of Strategy and Planning

Report author: Mr Shaun Ayres

Overall Position

The planning framework is clearer and better structured, however the evidence does not yet show a fully deliverable position.

Over the past year we have secured de-escalation in four areas. We remain at Level 4 for finance, strategy and planning, urgent and emergency care (UEC) and infection control, and at Level 3 for planned care. We have submitted the 2026/27 Annual Plan, strengthened integrated planning, and moved the Clinical Services Plan (CSP) into implementation planning.

Summary against criteria 5 to 9

- Criterion 5, Annual Plan: submitted, but not yet acceptable to the Board or Welsh Government. (Alert)
- Criterion 6, integrated planning: improving, but not yet consistently deliverable. (Advise)
- Criterion 7, CSP: roadmap established and well-evidenced, implementation early. (Assure)
- Criterion 8, planning maturity: improving, but gated by the plan's acceptability; the integrative criterion. (Advise)
- Criterion 9, regional planning: active across priority services, impact not yet evidenced. (Advise)

In short: The direction is clearer, but we cannot yet show the Plan is acceptable or that regional planning is delivering.

Feedback and Our Response

Welsh Government has not accepted the Plan. Our response is to evidence deliverability, not redescribe process.

What Welsh Government has said

- The Plan, as submitted, is not acceptable to either the Board or Welsh Government.
- Feedback centres on the clarity of commitments, deliverability, and trajectories below expectation in some areas.
- On planning maturity, our self-assessment was recognised for its transparency, but the evidence behind the scores was judged too high-level. The Health Board is due to re-run this exercise in the next month.

Our planning response

- We are building an evidence bridge from the submitted Plan to the latest validated position, the trajectory assumptions and the choices available.
- Delivery is profiled by quarter and month as a single control baseline, and the first quarter is being used to validate commitments and dependencies.
- We are recruiting three heads of service planning and improvement to build planning capacity and produce more worked-up, deliverable plans.

The financial recovery route, savings and control total sit with the Finance and Performance Committee (FPC) and are not repeated here.

Criterion 5: Acceptable Annual Plan

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We have submitted the Plan, but neither the Board nor Welsh Government yet regard it as acceptable.

What the evidence shows

- We approved and submitted the 2026/27 Annual Plan with a planned deficit of £41.0m, against a Welsh Government control total of £22.1m.
- Welsh Government feedback centres on the clarity of commitments, deliverability and trajectories below expectation, not on the planning process itself.
- Unlike last year, the Plan does not yet set out a credible route to improvement across all domains or to all the de-escalation criteria.

What this means: the planning process is sound, but the engagement can be variable, this is where the Heads of Service Planning and improvement become essential. The plan does not yet meet the standard of acceptability the framework requires. The financial recovery route is owned and reported by the FPC.

Assessment: Alert. Use the first quarter de-risking to validate commitments and dependencies, and evidence a credible route to £41.0m and then towards the control total.

Criterion 6: Integrated Planning

Integrated planning is more visible and better structured, but coherence does not yet convert into consistent delivery.

What the evidence shows

- The Plan was built through a risk-led process from July 2025, with integrated chapters across Clinical Care Groups (CCGs), workforce, estates, finance and Public Health.
- It uses a single control baseline for trajectories, workforce assumptions and quality constraints.
- Delivery against the 2025/26 Plan remained mixed, and the 2026/27 position still shows tension between financial assumptions, workforce capacity and operational feasibility.

What this means: the model is now established on paper. The gap is consistent deliverability in practice.

Assessment: Advise. Strengthen the link between planning assumptions and delivery confidence, embed a continuous medium-term cycle, and recruit three heads of service planning and improvement to build that capability and capacity within the Health Board.

Criterion 7: Clinical Services Plan

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The roadmap is established and well-evidenced. Implementation is now the test.

What the evidence shows

- The consultation ran for 13.5 weeks and drew more than 4,100 questionnaire responses.
- The programme tested clinical sustainability, accessibility, deliverability, strategic fit and financial sustainability.
- The Board has approved eight of the nine services in scope and is beginning a second-phase consultation on stroke including events at Prince Philip Hospital (PPH) on 5 June 2026; the programme has moved into Phase 4, implementation planning.

What this means: the planning route gives assurance on the roadmap. The area that will need to be monitored is implementation maturity and pace, and the wider response to service fragility. Put simply, once the plans are agreed, does the Health Board have credible and deliverable implementation plans. Clinical service change is cross-referenced to the Quality, Safety and Experience Committee (QSEC).

Assessment: Assure, with a watch on pace. Complete service-level implementation plans, conclude the stroke process, and set out the strategic response to wider service fragility (including the development of the Fragile Services register, monitored through QSEC).

Criterion 8: Planning Maturity

Planning maturity is improving, but this is the integrative criterion, and it is held back by the plan it rests on.

What the evidence shows

- Welsh Government recognised our self-assessment for its transparency and self-critique; but judged the supporting evidence too high-level.
- This criterion draws on Criteria 5, 6, 7 and 9, so it cannot rise above the Annual Plan's acceptability: the CSP lifts it, the plan (criterion 5) holds it back.
- We are building planning capacity, including three heads of service planning and improvement, and rebuilding the maturity evidence around milestones, ownership and deliverability. However, given the variability in the planning process, due to extreme operational pressures, the feedback reflects some aspects of that, but also the reality of trying to balance finance, performance, workforce, quality etc.

What this means: process maturity has improved faster than confidence in delivery, and that confidence will not move until the Plan is acceptable. However, to achieve that the third evidence point above becomes the most realistic route to achieving maturity, but, we must be cognisant of the challenges of balancing finite resources.

Assessment: Advise (could be alert), constrained by Criterion 5. Strengthen the evidence and ownership behind delivery, and resubmit a maturity position grounded in specific examples, not bullet points.

Criterion 9: Regional Planning

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Regional planning is active, but we cannot yet show it is delivering.

What the evidence shows

- Regional working spans orthopaedics, ophthalmology, stroke, pathology and cancer, aligned across south-west Wales and Mid Wales and increasingly to joint workforce.
- Orthopaedic regionalisation has plateaued: the long-term agreements for elective orthopaedics are unresolved and are limiting progress, and delivery to date is proof of concept rather than transformation.
- Stroke is the most advanced, but it is pre-decision; Welsh Government has criticised the absence of regional planning impact.

What this means: expectations and delivery are not hanging together. We cannot legitimately advocate that regional planning is delivering, which is why this moves to Alert.

Assessment: Alert. Agree the regional financial and contractual framework, including a pooled commissioning route through the Regional Joint Committee (RJC) for orthopaedics, and set a specialty-by-specialty recovery position with owners and measurable milestones, specifically around the deliverables and what is genuinely deliverable within the resources available across both Health Boards and the capability and capacity regionally.

Cross-cutting Reading

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Across Criteria 5 to 9, the consistent issue is not absence of planning, although it can be variable, but the overriding issue is the limited confidence in delivery.

We can show clearer structures and a firmer strategic direction. The recurring weakness is that deliverable evidence and demonstrated impact have not caught up with the planning architecture. Whilst, a number of structures exist, a reasonable question is whether they are achieving their intended outputs and outcomes, especially for the Annual Plan and Maturity Matrix.

The criteria interlock; they are not independent

- Criterion 6 is the planning capability; Criteria 5, 7 and 9 are the products it generates.
- Criterion 8 is the integrative judgement of confidence in delivery, and cannot rise above its weakest critical dependency: the CSP lifts it, the unacceptable plan and regional working hold it back.

Recurring themes

- Across all five, the evidence is strong on process and elements of outputs (i.e. the Health Board did produce a Plan), and weak on outcome and impact.
- A Plan exists, but it is not yet acceptable; regional planning is active, but its impact is limited and not yet evidenced.

Recommendation

The Committee is asked to:

- **NOTE** and **SCRUTINISE** that, against Criteria 5 to 9, the Plan is not yet acceptable (Criterion 5) and regional planning cannot yet be shown to be delivering (Criterion 9), with Criterion 8 constrained and close to Alert.
- **ACCEPT** and/or **CHALLENGE** the assessment: two criteria at Alert, one constrained, and assurance only on the CSP roadmap.
- **CONSIDER** a specialty-by-specialty regional recovery position, including resolution of the orthopaedic financial and contractual framework, with owners and measurable milestones.
- **SUPPORT** the direction of travel, including the planning-capacity build, including three heads of service planning and improvement, and the evidence-bridge work to move the plan towards acceptability.