

Special Measures De-escalation Criteria

Finance de-escalation criteria

Level 5 > 4	Level 4 > 3
<ol style="list-style-type: none"> 1) Demonstrated improvement and evidence of robust financial governance and a robust financial control environment. 2) Substantial progress to be made in delivering the SM action plan including actions to improve the organisation's understanding of the existing deficit and key drivers, development and realisation of opportunities. 3) Annual Plan developed with Board approval demonstrating a substantial financial improvement trajectory to deliver as a minimum, the target control total. 	<ol style="list-style-type: none"> 1) The health board must demonstrate that there are robust financial governance and robust financial control environment in place with risks minimised. 2) Substantial progress to be made in delivering the targeted intervention action plan including actions to improve the organisation's understanding of the existing deficit and key drivers and development and realisation of opportunities. 3) Annual plan developed with board approval demonstrating a substantial financial improvement trajectory to deliver as a minimum, the target control total.

Strategy and Planning de-escalation criteria

Level 5 > 4	Level 4 > 3
<ol style="list-style-type: none"> 1) Submission of an approvable annual plan in line with the NHS Wales planning framework 2024 to 2027. 2) Evidence of improving integrated planning across the organisation which supports the development of a coherent and deliverable annual plan. 3) Board clarity on the strategic vision for the organisation. 4) Evidence of a clear roadmap and implementation of the health board's multi-professional clinical services plan. 5) Deliver commitments set out within the annual plan, particularly in relation to the ministerial priorities. 6) Sustained improvements in delivery of the plan throughout the year. 7) Welsh Government's confidence in delivery based on the health board self-assessment against the planning maturity matrix. 	<ol style="list-style-type: none"> 1) Submission of an acceptable annual plan in line with the current planning framework. 2) Evidence of integrated planning across the organisation which supports the development of a coherent and deliverable annual plan. 3) Board clarity on the strategic vision for the organisation. 4) Evidence of a clear roadmap and implementation of the health board's Clinical Services Plan. 5) Delivery of commitments set out within the annual plan, particularly in relation to the ministerial priorities. 6) Significant progress on a clinical services plan. 7) Sustained improvements in delivery of the plan throughout the year. 8) Welsh Government's confidence in delivery based on an assessment against the planning maturity matrix and planning quadrant. 9) Establishment of a Joint Committee and demonstrate improved regional collaboration where required to ensure continued safety, quality and ongoing viability and sustainability of regional services; including orthopaedics and ophthalmology.

Planned Care and Cancer de-escalation criteria

Level 5 > 4	Level 4 > 3
<ol style="list-style-type: none"> 1) 55% performance maintained for 4 months against the SCP target. 2) 98% of open outpatient pathways are waiting less than 52 weeks and maintained for 4 months 3) Continuous improvement to ensure that 97% of open pathways are waiting less than 104 weeks and maintained/improved for 4 months. 4) Continuous reduction in the number of patients delayed by 100% for their follow up appointment. 5) 75% of patients waiting for a diagnostic test to be waiting less than 8 weeks maintained for 4 months. 6) 80% of patients waiting for therapies to be waiting less than 14 weeks and maintained for 4 months. 	<ol style="list-style-type: none"> 1) 60% performance maintained for 3 months against the SCP target. 2) 100% of open outpatient pathways to be waiting less than 52 weeks and maintained for 3 months. 3) 100% of open pathways to be waiting less than 104 weeks and maintained for 3 months. 4) 80% of open pathways to be waiting less than 52 weeks and maintained for 3 months. 5) 15% reduction in the number of patients delayed by 100% for their follow up appointment in three consecutive months and maintained for 3 months (Based on the November 2023 baseline.) 6) 65% R1 ophthalmology patient pathways to be waiting within or no longer than 25% of their target date for an outpatient appointment and maintained for 3 months. 7) 80% of patients waiting for a diagnostic test to be waiting less than 8 weeks and maintained for 3 months. 8) 80% of patients waiting for a diagnostic endoscopy to be waiting less than 8 weeks and maintained for 3 months. 9) 80% of patients waiting for a NOUS and non-cardiac MRI to be waiting less than 8 weeks and maintained for 3 months. 10) 85% of patients waiting for therapies to be waiting less than 14 weeks and maintained for 3 months. 11) Improving ratings from service user feedback experience responses and evidence of use of Datix and CIVICA data to inform quality improvement processes and the experience of patients and their families.

Urgent and Emergency Care de-escalation criteria

Level 5 > 4	Level 4 > 3
<ol style="list-style-type: none"> 1) Continuous reduction of ambulance handovers over one hour of at least 17% maintained over 4 consecutive months. 2) Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60 minutes. 3) Continuous improvement towards no more than 10% of patients waiting over 12 hours at each individual site and across the health board. 4) Continuous reduction of 5% in pathways of care delays for 3 consecutive months and then maintained for 4 months. 5) Evidence of use of Datix and CIVICA data to inform quality improvement processes and the experience of patients and their families. 	<ol style="list-style-type: none"> 1) A continuous reduction of ambulance handovers over an hour of at least 11% in three consecutive months and maintained for 3 months (Based on the Oct-Dec 2023 baseline). 2) Continuous improvement towards no more than 7% of patients waiting over 12 hours at each individual site and across the health board. 3) Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60 minutes. 4) A continuous reduction in delayed pathways of care of 5% for three consecutive months and then maintained for three months (based on Oct-Dec 23 baseline). 5) Improving ratings from service user feedback experience responses and evidence of use of Datix and CIVICA data to inform quality improvement processes and the experience of patients and their families.

Adult Mental Health and CAMHS de-escalation criteria

Level 5 > 4	Level 4 > 3
<p>Adult Mental Health</p> <ol style="list-style-type: none"> 65% of LPMHSS mental health assessments undertaken within 28 days from the date of receipt of referral for 4 months (Part 1a). 65% of therapeutic interventions started within 28 days following an assessment by LPMHSS for 4 months (Part 1b). 65% of HB residents in receipt of secondary mental health services who have a valid care and treatment plan for 4 months (Part 2). <p>CAMHS</p> <ol style="list-style-type: none"> 75% of LPMHSS mental health assessments undertaken within 28 days from the date of receipt of referral for 4 months (Part 1a). 60% of therapeutic interventions started within 28 days following an assessment by LPMHSS for 4 months (Part 1b). 75% of HB residents in receipt of secondary mental health services who have a valid care and treatment plan for 4 months (Part 2). 	<p>Adult Mental Health</p> <p>Not covered in the Hywel Dda de-escalation criteria.</p> <p>CAMHS</p> <ol style="list-style-type: none"> 80% of LPMHSS mental health assessments undertaken within 28 days from the date of receipt of referral. 65% of therapeutic interventions started within 28 days following an assessment by LPMHSS. 80% of HB residents in receipt of secondary mental health services who have a valid care and treatment plan.

Primary and Community Care de-escalation criteria

Level 5 > 4	Level 4 > 3
<ol style="list-style-type: none"> Primary and community care is supported by strong clinical leadership, at Board and Executive level, an effective integrated improvement plan, project management structure and effective transformation support. Evidence of improved activity within community opportunities, urgent primary care centres A clear strategy and plans for GMS managed practices, and fragile GMS practices. All GDS and PDS dental contracts in place with a clear plan for the commissioning of tier 2 dental services across North Wales. 	<p>Not covered in the Hywel Dda de-escalation criteria.</p>

Fragile Services de-escalation criteria

Level 5 > 4	Level 4 > 3
<ol style="list-style-type: none"> 1) Evidence that the health board has the appropriate mechanism to understand the drivers behind a fragile service through the triangulation of key data points, including staffing levels, staff and patient feedback, concerns, incidents, stakeholder feedback (HIW, AW, HM Coroners, Royal Colleges, HTA, MHRA, Llais etc), mortality reviews, duty of quality/candour, infection prevention and control, performance, clinical and medical leadership. 2) For each fragile service evidence: <ul style="list-style-type: none"> • Whether staff have all the information they need to deliver safe care and treatment to people? • How are people's care and treatment outcomes monitored and how do they compare with other similar services? • How does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment? • How well do staff, teams and services work together within and across organisations to deliver effective care and treatment? • How consent to care and treatment is sought in line with legislation and guidance? • Clear and effective processes for managing risks, issues and performance. 3) Fragile services (as highlighted above) are supported by strong clinical leadership, have an effective integrated improvement plan, project management structure and effective transformation support. Where appropriate, key performance metrics will be agreed. 4) Evidence that all recommendations from the Royal Colleges, HIW and other reviews are discharged and either verified or delivered or scheduled for delivery within the health board's longer-term improvement plan. 5) Evidence that the Board is sighted on fragile services and has a robust response to these issues that is being addressed by the health board. 	<ol style="list-style-type: none"> 1) Evidence that the health board has the appropriate mechanism to understand the drivers behind a fragile service through the triangulation of key data points, including staffing levels, staff and patient feedback, concerns, incidents, stakeholder feedback (HIW, AW, HMC, RC, Llais etc), mortality reviews, duty of quality/candour, infection protection control, performance, clinical and medical leadership. 2) Fragile services (including but not limited to stroke, primary care, orthopaedics and ophthalmology) are supported by strong clinical leadership, have an effective integrated improvement plan, project management structure and effective transformation support. Where appropriate key performance metrics will be agreed. 3) Evidence that all recommendations from the Royal Colleges, HIW and other reviews specific to Hywel Dda UHB are discharged and either verified or delivered or scheduled for delivery within the health board's longer-term improvement plan. 4) Evidence that the Board is sighted on fragile services and has a robust response to these issues that is being addressed by the health board 5)

Governance de-escalation criteria

Level 5 > 4	Level 4 > 3
<ol style="list-style-type: none"> 1) A vision, credible strategy and supporting plans to deliver organisational priorities which are underpinned by a culture of quality, sustainable care. 2) Governance and assurance systems in place with performance (quality, resource, activity/outcomes) issues escalated appropriately through clear structures and processes with effective Board oversight and a clear performance and delivery framework that drives improvement. 3) Responsibilities, roles and systems of accountability and escalation to support good governance and management. 4) Effective oversight and scrutiny being consistently provided by the Board and/or the appropriate Committee with clear evidence, recommendations, risks and opportunities outlined in Committee and Board papers. 5) An effective risk management framework for identifying, recording and managing risks across the organisation. The Board and the relevant Committee is sighted on the organisation's strategic risks and areas of concern on a regular basis. 6) Processes ensure the Board and the relevant Committees are provided with regular reports on performance to maintain an appropriate level of oversight and so they can scrutinise effectively. 7) Processes ensure the Board and the relevant Committees are provided with regular reports on fragile services so that they can maintain an appropriate level of oversight and so they can scrutinise effectively and provide guidance. 8) Clinical strategy and supporting plans are developed, agreed and communicated internally and to the public; deliver realistic actions early on to gain confidence and trust that sustainable longer-term continuous improvement is achievable. 9) Regular self-assessment against the agreed governance framework to identify risks and opportunities and ensure continuous improvement. 	<ol style="list-style-type: none"> 1) Effective oversight and scrutiny of current service provision consistently being provided by the Board and the appropriate Committee as demonstrated by Committee and Board papers. 2) Evidence of Board considering the Duty of Quality to inform their decision making and evaluating their compliance with the Duty. 3) Effective programme and performance management structure is in place, which defines objectives of the improvement work, has plans which show how the work is delivered and what barriers could impact on delivery of outcomes; structures have effective, open and transparent reporting, with effective Board oversight and a clear performance and delivery framework that drives improvement. 4) Risk management arrangements are in place for identifying, recording, managing risks across the organisation. Board is sighted on key risks and areas of concern on a regular basis and is able to offer constructive scrutiny on performance and effective oversight and scrutiny of fragile services provided by QSE and Board. 5) Clear governance and assurance systems in place with performance (quality, resource, activity/outcomes) issues escalated appropriately through clear structures and processes. 6) Self-assessment against an agreed governance maturity matrix with evidence the agreed level.

Leadership, Capability and Culture de-escalation criteria

Level 5 > 4	Level 4 > 3
<ol style="list-style-type: none"> 1) Succession and development plan in place to ensure adequate capacity and capability in all areas of the organisation. 2) A clear organisational structure led by an effective and complete executive team with the leadership capacity and capability to deliver high quality, sustainable care. 	<ol style="list-style-type: none"> 1) A full and substantive Executive Director Team, with a clear organisational structure is in place with robust succession and development plans in place to ensure adequate capacity and capability in all areas of the organisation to deliver high quality, sustainable care. 2) Effective leadership programmes are in place to support the ongoing development of leadership and

<ul style="list-style-type: none"> 3) Effective leadership programme in place to support ongoing development of leadership and management skills at all levels/professions to strengthen management maturity. 4) Strategic workforce planning is undertaken to maximise skills of current staff. 5) Continued embedding of a values and behaviours framework throughout the organisation. 6) Systems and processes for learning, continuous improvement and innovation. 7) Mechanisms in place to ensure lessons learned are recorded, communicated and used to drive improvements. 8) Positive staff engagement in NHS Wales surveys. 9) Local surveys showing increasing confidence and trust in the organisation's leaders and an awareness of strategies. 10) Plans are in place and being implemented to reduce the number of interim and agency staff. 11) Positive feedback from leadership programmes. 12) A culture of listening, learning, and improving is embedded throughout the organisation based on early and rapid triangulation and resolution of issues from a variety of sources, including patient, user and staff feedback. 13) Demonstrate how people's concerns and complaints are listened to, and responded to, and used to improve the quality of care and how the people who use services, the public, staff and external partners are engaged and involved to support high quality sustainable services 	<p>management skills at all levels / professions to strengthen management maturity. Evaluation of the impact of these programmes including decision making, use of equality impact assessment, safeguarding and participant feedback.</p> <ul style="list-style-type: none"> 3) Positive staff engagement in NHS Wales surveys. 4) Plans are in place to develop a sustainable workforce resulted in improved staff retention and staff well-being, a reduction in the number of vacancies and the number of interim and agency staff, workforce plans and clinician job plans are reviewed annually to ensure that the organisation can deliver the requirements of the annual plan 5) Whether the people who use services, the public, staff and external partners are engaged and involved to support high quality sustainable services, demonstrated by local surveys showing increasing confidence in the leadership and awareness of strategies. 6) Clinical change is led and driven forward by clinical leaders at all levels of the organisation. 7) A culture of listening, learning, and improving is embedded throughout the organisation based on early and rapid triangulation and resolution of issues from a variety of sources, including quality, mortality, staffing levels, patient outcomes, user and staff feedback. 8) Effective use of data to help demonstrate improvements in leadership.
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Quality of Care de-escalation criteria

Level 5 > 4	Level 4 > 3
<ul style="list-style-type: none"> 1) An integrated and effective quality management system operating throughout the organisation. 2) Stabilisation of the increased trajectory of cases of HCAI and evidence of continuous improvement accompanied by a strong QI approach and plan that has oversight and monitoring by Quality, Safety and Experience Committee and Board. 3) The health board to have a clear improvement plan based on a root cause analysis to address the issue of hospital onset HCAIs. <ul style="list-style-type: none"> a. C-Diff: reduce the number of hospital onset infections by 15% and maintain for 4 months (from a baseline of the average number of cases in quarter 3 of 13 cases to no more than 11 per month) b. E-coli: reduce the number of hospital onset infections by 15% and maintain for 4 months (from a baseline of the average number of cases in quarter 3 of 10 cases to no more than 8 per month) 	<ul style="list-style-type: none"> 1) Stabilisation of the increased trajectory of cases of HCAI and evidence of continuous improvement accompanied by a strong QI approach and plan that has oversight and monitoring by Quality Safety Committee and the Health Board to have a clear improvement plan based on a root cause analysis to address the issue of hospital onset HCAIs. <ul style="list-style-type: none"> a. C-Diff: reduce the number of hospital onset infections by 25% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 8 cases to no more than 6 per month). b. Staph aureus: reduce the number of hospital onset infections by 33% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 3 cases to no more than 2 per month) c. E-coli: reduce the number of hospital onset infections by 25% and maintain for 3 months (from

- 4) 68% of complaints that had final reply (Reg 24)/interim reply (Reg 26) to be closed within less than 30 working days of concern received maintained for 3 months
- 5) Effective response from the health board to external reports and reviews including those from Audit Wales, Public Services Ombudsman, Royal Colleges and HIW resulting in sustainable improvements.
- 6) Demonstrate how service user and staff experience/involvement is being used to improve quality processes and inform service development across the organisation.
- 7) Demonstrate the progress made against implementing the requirements of the Duty of Candour and Duty of Quality including the embedding of the Care and Quality Standards throughout the organisation from Board to service area delivery.
- 8) Oversight of safeguarding arrangements to ensure the Board has sufficient, meaningful assurance that the organisation is delivering against its safeguarding statutory responsibilities.
- 9) Use of national clinical audit and outcome review programme and Value in Health dashboards to support quality improvement and address unwarranted variation in care (including the use of patient and staff feedback to influence service design).

- a baseline of the average number of cases in quarter 3 of 7 cases to no more than 5 per month).
- 2) 70% of complaints that had final reply (Reg 24)/interim reply (Reg 26) to be closed less than 30 working days of concern received.
 - 3) Effective response from the health board to external reports and reviews including those from Audit Wales, the Ombudsman, Royal Colleges and HIW resulting in sustainable improvements.
 - 4) Demonstrate how service user and staff experience/involvement is being used to improve quality processes and inform service development across the organisation.
 - 5) Demonstrate the progress made against implementing the requirements of the Duty of Candour and Duty of Quality including the embedding of the Care and Quality Standards through the organisation from Board to service area delivery.
 - 6) Oversight of safeguarding arrangements to ensure the board have sufficient, meaningful assurance that organisation is delivering against its safeguarding statutory responsibilities.
 - 7) Use of National Clinical Audit and Outcome Review Programme and Value in Health dashboards to support quality improvement and address unwarranted variation in care. (including the use of patient and staff feedback to influence service design).