Meeting Date	**28th March 2019**	**Agenda Item**	**5.1**
Report Title	Report on the Implementation of the Annual Plan 2018/19 - Quarter 3		
Report Author	Ffion Ansari, Head of IMTP Development and Implementation Nicola Johnson, Interim Assistant Director of Strategy		
Report Sponsor	Siân Harrop-Griffiths, Director of Strategy		
Presented by	Siân Harrop-Griffiths, Director of Strategy		
Freedom of Information	Open		
Purpose of the Report	The paper provides the Board with a report on the implementation of the Annual Plan at the end of quarter 3 2018/19. The report has been assured by the Performance and Finance Committee in February.		
Key Issues	The paper is a covering report for the detailed monitoring of the plans which were included in the Annual Plan 2018/19 which is included at **Appendix A**. These support the delivery of the Aim and Objectives which were laid out in the Plan and the achievement of the actions for each Objective is shown. The Plan was based on five Service Improvement Plans for our Targeted Intervention Improvement areas and the report also describes the progress with delivering these Service Improvement Plans. The report describes the completed or on-track actions. Detailed feedback is given on the off-track actions including improvement actions and revised milestones. The paper should be read in conjunction with the Health Board's full performance report.		
Specific Action Required ***(please ✓one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
			✓	✓
Recommendations	Members are asked to: - • **ENDORSE** the Quarter 3 report on the implementation of the Annual Plan 2018/19; and, • **NOTE** it will be submitted to Welsh Government for assurance purposes.			

QUARTER 3 REPORT ON THE IMPLEMENTATION OF THE ANNUAL PLAN 2018/19

1.0 Introduction

The purpose of this paper is to provide the Board with a report on the achievement of the Health Board's Corporate Objectives and actions set out within the Annual Plan 2018/19, as at the end of Quarter 3.

This report is not intended to be a full description of the performance delivery of the Annual Plan as this is subject to more detailed in commentary in the main Health Board performance report. However detailed feedback on the off-track actions is included including our improvement actions and revised milestones.

2.0 Background

The Annual Plan implementation monitoring report for Quarter 3 is attached at **Appendix A** for the Board's consideration. **Appendix A** is the detailed internal monitoring return and the narrative explanation and summary commentary is included for ease of reference in this covering paper. This report should be considered in tandem with the main Health Board performance report.

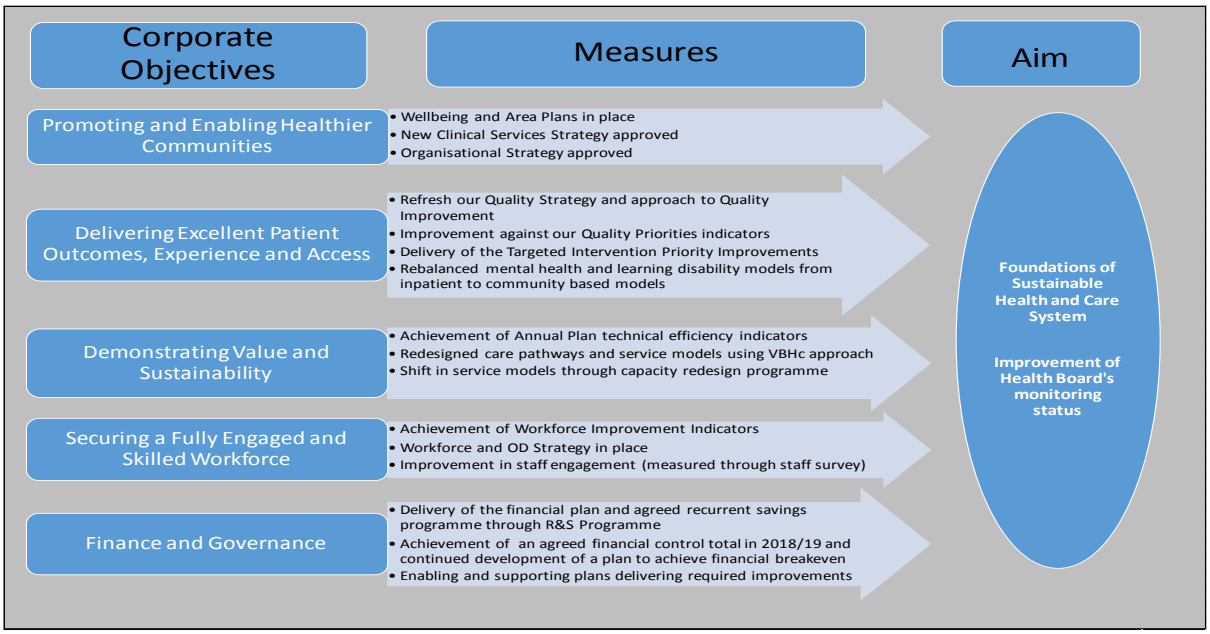
The report has been assured by the Performance and Finance Committee in February.

3.0 Assessment

This year the assessment has been undertaken through two lenses; the achievement of the Corporate Objectives to achieve the Aim of the Plan, and the implementation of the detailed Service Improvement Plans for our Targeted Intervention improvement priorities of Unscheduled Care, Stroke, Planned Care, Cancer and Healthcare Acquired Infections. The detail behind both of these elements is included in the detailed monitoring return with the higher level measures used to monitor achievement of our Objectives numbered with an 'M' prefix and the actions in the Action Plans having an 'A' prefix. .

3.1 Overall Assessment of Achievement of our Corporate Objectives and Service Improvement Plans

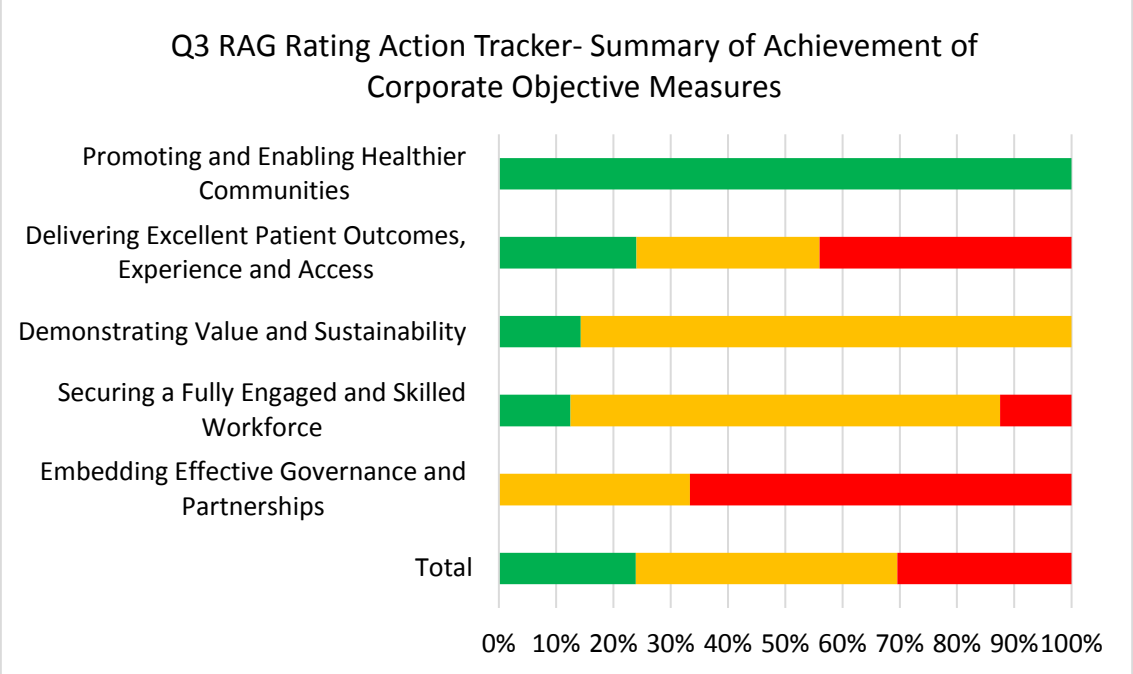
The Annual Plan 2018/19 outlined our Corporate Objectives to achieve our overall Aim of setting the foundation for future sustainability and improvement of our monitoring status. High-level measures were described to be able to monitor success in achieving the Objectives as shown in the diagram below.



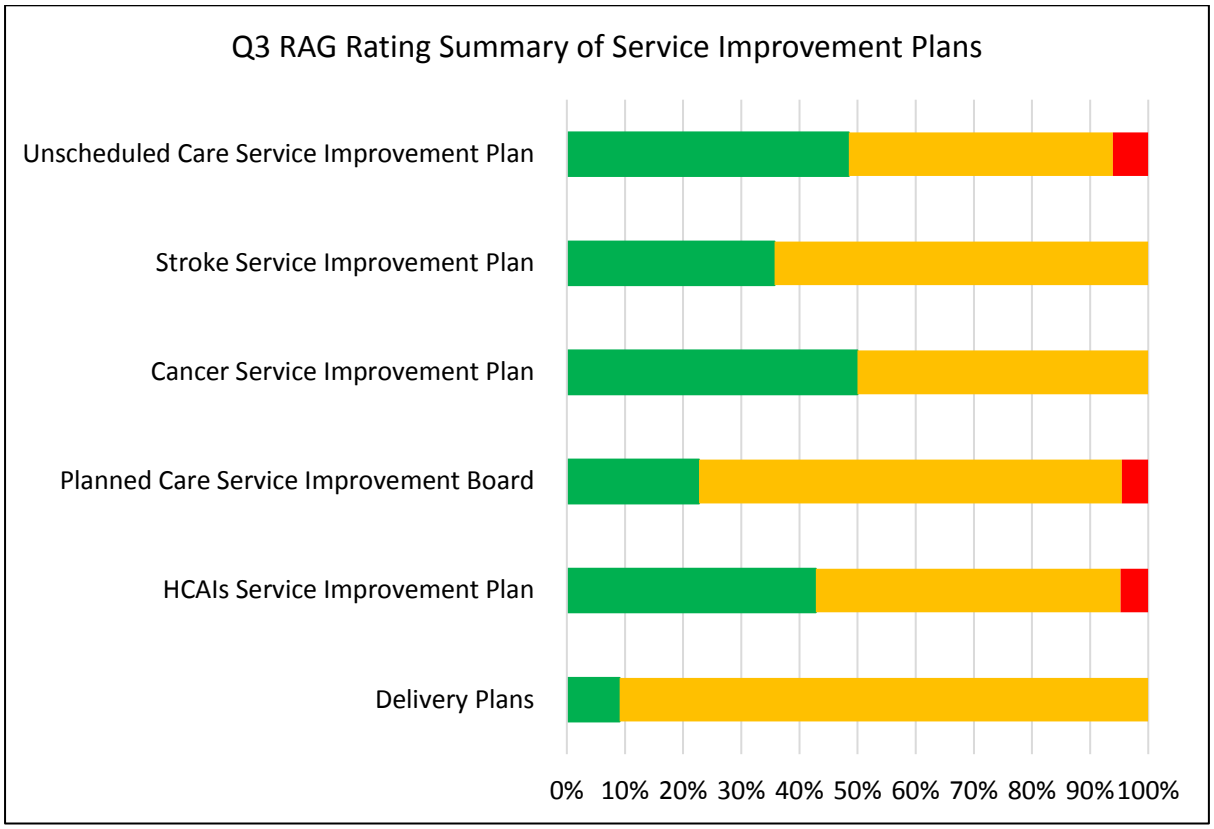
The detailed monitoring report is structured to report on our Corporate Objectives using colour-coded headings for each Corporate Objective as follows:

Promoting and Enabling Healthier Communities
Delivering Excellent Patient Outcomes, Experience and Access
Demonstrating Value and Sustainability
Securing a Fully Engaged and Skilled Workforce
Embedding Effective Governance and Partnerships

Performance is assessed on a Red/Amber/Green (RAG) system. The overall summary of achievement of the 45 key performance indicators against the Corporate Objectives ('M' indicators) at the end of Quarter 3 is set out in the figure below.



The Annual Plan for 2018/19 also described five Service Improvement Plans for our Targeted Intervention improvement areas. The overall assessment of achievement of the actions in the Service Improvement Plans is shown below.



The two charts show that there is good progress with delivering our Service Improvement Plans, with very few off-track actions. The delivery of our plans is underpinning good progress in delivering our Corporate Objectives, particularly around promoting and enabling healthier communities. However at the end of Quarter 3 we were off-track with achieving a number of our key objectives for delivering improved patient access and effective governance and partnerships (it should be noted however that in totality this objective only has seven 'M' actions with only 2 off track.)

3.2 Detailed Assessment of Achievement of Plans

The monitoring shows that at the end of Quarter 3 there were 74 plans which were either on-track or completed (42%) and 7 off-track plans (4%). The remainder are in progress.

RAG Rating	Number of Actions	%
Red	6	3
Amber	90	51
Green	76	43
Not rated	6	3
Total	178	100

Three actions which were not rated relate to the Heart Disease, Neurological Conditions and Critically Ill Delivery Plans. Due to Executive and management lead changes these remain a risk which the Health Board will resolve now that the full Executive Team is in place and will be linked to development of our next IMTP and integrated planning system including the Transformation Portfolio.

The next sections describe the completed or on-track actions and provide detailed feedback on the off-track actions, including improvement actions and revised milestones.

3.2.1 Actions which are completed or on-track

A summary of our actions which are completed or on-track are shown below.

Corporate Objective	On-Track or Completed Actions
Promoting and Enabling Healthier Communities	• The Board has approved its Organisational Strategy and has made excellent progress in developing its Clinical Services Plan for approval in January 2019. • The Direct-Acting Oral Anticoagulants (DOAC) Local Enhanced service has now been commissioned from GP practices. • Work to increase physical activity in key target groups is progressing with the Physical Activity Alliance Group established and the Healthy and Active Fund bids developed. • We continue to improve health literacy within the population as part of a preventative approach with Health Literacy communication skills training for health professionals delivered in Quarter 3 and positive work continues with the roll-out of Making Every Contact Count. • As part of the preparation for the implementation of the Single Cancer Pathway in April 2019, a full demand and capacity profiling exercise of USC, Urgent and Routine work has been undertaken for the Endoscopy service delivered via the NPTH, Singleton and Morriston units, a prototype live queue dashboard has been developed and verified and process mapping of Pathology services has been completed. • Work remains on track around preventing HCAIs including work on promoting the importance of hydration, reduction in antibiotic usage and catheters.
Delivering Excellent Patient Outcomes, Experience and Access	• The Health Board is continuing to make progress in reducing harm from falls with the number of falls resulting in harm reducing 7% compared to the same period in 2017/18. • We have made progress in the development of EMI care Home in-reach services with teams operational in each local authority area with early indications in NPT are

Corporate Objective	On-Track or Completed Actions
	showing reductions in the length of stay on PPMHS acute ward with the timely facilitation of discharge. • Implemented plans to enhance and develop frailty models during the year within existing resources including: TOCALs into Neath Port Talbot Hospital; multi-disciplinary older person's service at Singleton hospital (ICOP); Embedding the redesigned frailty model at POW; and implementation of the older person's assessment service at the front door of Morriston hospital. • Bed Utilisation Survey was undertaken on 3rd October. • In our target intervention priority area of Unscheduled Care we: o Continue to meet the target for emergency responses to red calls. o Continue to maximise the use of the 111 model including reaching agreements on using nurses undertaking dace to dace appointment in Urgent Primary Care and Paramedics undertaking all evening and overnight home visits under an SLA with WAST. o Expanded remote working GPs to 37, improving access to GP care. o Continue to develop ambulatory care models across the Health Board. o Frailty at the Front Door models have been developed on all three main hospital sites. • In our target intervention priority area of Planned Care we: o Achieved the Health Board profile for Quarter 3 for the number of patients waiting more than 36 weeks for treatment, with an improvement of 1,686 (the best position since June 2014). o Rolled out and developed the use of e-referrals with 98% of e-referrals prioritised electronically in Quarter 3. o Continue to work with partner Health Board to identify regional solutions to deliver routine elective surgery specifically around Orthopaedics. o RTT capacity plans are in place which delivers the health board year end profile of 2,664 for patients waiting over 36 weeks and Nil for patients waiting over 26 weeks for a first outpatient appointment. • In our target intervention priority area of Stroke we: o Met three of the four stroke targets (Direct admission to Acute Stroke Unit within four hours, CT scan within one hour and Assessment by a Stroke Consultant Specialist Physician within 24 hours). • In our target intervention priority area of HCAIs we: o Improved on our profiled position for C.Difficile reductions with approximately 28%fewer cases compared to the same period in 2017/18.

Corporate Objective	On-Track or Completed Actions
	o Delivered hand hygiene compliance for quarter three (97%) with Delivery Units having commenced peer review programme. o Education on revised decolonisation protocol delivered to all wards and units on secondary care sites. • In our target intervention priority area of Cancer we: o Undertaken a full capacity review. o Continued to work towards providing services with a visual interface of queues at the different component stages of the current cancer pathways. So that accurate and up-to-date information in relation to demand and activity is available and services are able to monitor and react to in real time, actively managing before the breaches occur. o New MDT Co-ordinator job description implemented across the Health Board. o Continued to fully engage with the peer review process recently participating in the second cycle review for Breast Services and the first cycle for Thyroid, and for Acute Oncology Services. o Established the Macmillan Strategic Lead Cancer Nurse in post as of the 1st October 2018
Demonstrating Value and Sustainability	• The Annual Plan 2018/19 identified drivers to reduce the volume of outpatient referrals through increased use of e-referrals within individual GP practices, and clinicians providing advice and feedback. A 1% reduction in referrals target equates to 28,060 referrals per month. In 2018/19 99,069 GP referrals have been received during April – September, 63.2% (62,612 via Electronic) and 36.8% (36,457) via paper.
Securing a Fully Engaged and Skilled Workforce	• We have reduced turnover within the first 12 months of employment. The data shows particular decreases within Additional Clinical Services and our Nursing and Midwifery staff groups. This improvement may have partly been facilitated due to the new Nursing and Midwifery strategy published in 2017 which placed a greater commitment to a providing clinical supervision for newly qualified nurses. • Speech and Language Therapy training sessions have been undertaken in Morriston and the new middle tier of medical staff are in the process of receiving thrombolysis training as part of continuing staff training and awareness sessions of the stroke pathway.
Embedding Effective Governance and Partnerships	• YTD positon at the end of month nine is £1.3m over the £10m control total target based on 9/12th of £20m less £2.5m of the additional WG support. This reflects the non-delivery of required savings and operational pressures, which has been partially offset by the release of identified mitigating opportunities, including slippage on some

Corporate Objective	On-Track or Completed Actions
	committed reserves and other recurrent and non-recurrent opportunities. There are plans to deliver the £10m forecast position. • The plan to deliver £10m control total in place and being robustly monitored. • The underlying position and impacts continue to be developed.

3.2.2 Actions which are off-track

Detailed feedback on the summary of the 9 actions which are off-track, our improvement actions and revised milestones is shown below. There are two actions which are assessed as requiring review by our new Executive Directors in Quarter Four as to whether they are still the right things to do as follows, and these are also marked in italics in the table:

- Refresh our Quality Strategy and approach to Quality Improvement
- Develop a business case for a 7-day Infection Control Team.

The majority of the other actions relate to achievement of our Targeted Intervention Priorities, Welsh Government targets or local efficiency indicators.

Corporate Objective	Off-Track Actions	Improvement Actions	Revised Milestone
Promoting and Enabling Healthier Communities	N/A	N/A	
Delivering Excellent Patient Outcomes, Experience and Access	*Refresh our Quality Strategy and approach to Quality Improvement*	• The refresh is off-track pending the new Director of Nursing and Medical Director taking up post (both in post by November), although Quality Priorities have been agreed to inform the development of the IMTP 2019-22. The respective Directors will advise on the way forward during Quarter 4.	Q4
	Stoke Care		
	Thrombolysis door to needle <= 45 mins	• Achieving Thrombolysis door to needle time has proven difficult – actions taken since August include the additional appointment of medical middle tier posts in Morriston to improve support to the A & E department and to improve access to timely thrombolysis, those eligible for thrombolysis receive the intervention in a timely way. • The Units were reviewed at the end of November as part of the all Wales thrombolysis review and recommendations from that process will be developed and actioned as appropriate.	Q4
	Planned Care		
	The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date	• The Health Board did not deliver against its profile at the end of Quarter Three although there was a slight improvement on Quarter Two. • Delivery Unit plans are developed with progress being monitored against their profiles through the Outpatient Improvement Group.	Q4

Corporate Objective	Off-Track Actions	Improvement Actions	Revised Milestone
		• Additional funding has been released through the IBG bid to support validation of the waiting lists with the planned expectation that this exercise will eradicate c6000 erroneous entries through Quarter Four.	
	Improvement Plan Actions		
	Baseline audit of Peripheral Venous Catheter (PVC) incidence in Delivery Units. Reinvigorate STOP campaign. Adhere to best practice guidance for insertion, maintenance and removal of PVC's.	• Information on PVC incidence was collected in pilot wards at Morriston; this is rolling out to other Delivery Units using PDSA improvement methodologies. • The use of bundles is monitored via Care Metric, the Quarter Three average compliance was as follows: o PVC insertion bundle - 76% o PVC maintenance bundle - 88%. • Delivery Units will ensure clinical staff adhere to the use of PVC bundles.	Q4
Demonstrating Value and Sustainability	N/A	N/A	
Securing a Fully Engaged and Skilled Workforce	Reduce sickness absence	• The 12 month rolling performance to the end of November 2018 is 5.93% and represents an overall decline in performance of 0.16% since the beginning of 2018/19. Whilst long term sickness rates continue to be a challenge there has been some improvement in the last two months and the current performance for November 2018 is 3.97% and is an improvement of 0.35% compared to reported levels at the same period last year. Absence due to anxiety /stress/depression remains the highest reason for absence and accounts for approximately a third of all absence. • Key actions to improve performance include: o Implementation of new all Wales Managing Attendance policy. o Commence training sessions for managers regarding the new all Wales Managing Attendance policy. o Development of a full training plan to support implementation of the new Attendance policy. o Outputs of a best practise case study conducted in three areas of good sickness performance have been shared with DUs and learning is to be	Q4

Corporate Objective	Off-Track Actions	Improvement Actions	Revised Milestone
		implemented via local sickness improvement plans all Units. o Development of a pilot within a selected area in order to address high absence, some of which will apply learning from the above best practise case study. o Occupational Health improvement plan complete and being implemented – this includes increasing capacity for management referrals in occupational health using AHP workforce and scanning of 35 000 staff records to enable efficiency savings related to e-records and e-systems. o Continue Flu vaccination programme which to date has seen 45% of frontline staff vaccinated (as at 17/11/18). o Continue delivery of Mental Health awareness sessions to managers. To date 16 sessions have been delivered to 132 managers. o Continue further delivery of work-related stress risk assessment training for managers. To date 24 sessions have been delivered to 210 managers in total o Currently developing new Attendance Audit for ABMUHB in line with New Managing Attendance At Work Policy. o Currently developing new Cultural Audit for ABMUHB to measure the culture of each department. o Development of a pilot focusing on early communication and support to aid early Return To Work for Short Term Absences. o Strategically align Health & Wellbeing plans with Attendance Management work stream. o Testing of Absence Data. o Development of a pilot within Facilities to test and exploit the benefits of using ESR Manager Self-Serve in managing absence more effectively.	
	Develop a business case for consideration by IBG for a 7 day Infection Control Service, that reflects the Delivery Unit structures and provides a	The case has been delayed pending the appointment of the new Assistant Director of Nursing for Infection Prevention and Control, who took up post in November. The post holder will advise if this action remains valid in Q4 as she assesses the Health Board's capacity to address the infection control issues.	Q4

Corporate Objective	Off-Track Actions	Improvement Actions	Revised Milestone
	sustainable workforce to support work streams of the HCAI Collaborative Drivers.		
Embedding Effective Governance and Partnerships	Agree joint outsourcing package and implement commissioning of the activity agreed LTA in place for both organisations as a commissioner.	• The outsourcing programme was not delivered fully in Quarter Three due to the inability of the main Provider to fulfil its contractual obligation. The contract was retracted and coverage for the full capacity lost in Quarter Three and planned capacity for Quarter Four has been secured across multiple providers, mitigating any risk of sole reliance on a single point of delivery. Outsourcing in line with the new contracts is well underway and will continue to the end of March 2019.	Q4
	Delivery of the financial plan and agreed recurrent savings programme through the R&S Programme	• Delivery has been managed through work streams aligned with the Recovery and Sustainability Programme. • The month nine tracker indicates that most areas are not delivering against the plans. • Mitigating actions have been agreed to support the achievement of control total • A six month review of actions was completed in October and further key actions identified for year end • A new workstream has been established to bring together all of the elements of medical workforce actions including a detailed review of junior doctor and ED rota's; implementation of locum on duty and e-job planning and other actions • Units have been asked to identify mitigating actions to offset non delivery of savings and these are being managed through regular Performance, Quality and Finance meetings.	Q4

4.0 Assurance and Governance

The report is considered regularly on behalf of the Board by the Performance and Finance Committee, as agreed during the development of the Annual Plan for 2018/19 before consideration by the Board. The Quarter 3 report was assured in February by the performance and Finance Committee.

Welsh Government requires each Health Board to forward the Board report on the quarterly reporting of progress of Annual Plan/IMTP implementation for assurance purposes and this document will be shared with Welsh Government for this purpose.

5.0 Recommendations
Members are asked to: -

- **ENDORSE** the Quarter 3 report on the implementation of the Annual Plan 2018/19; and,
- **NOTE** it will be submitted to Welsh Government for assurance purposes.

Governance and Assurance							
Link to corporate objectives ***(please ✓)***	Promoting and enabling healthier communities	Delivering excellent patient outcomes, experience and access	Demonstrating value and sustainability	Securing a fully engaged skilled workforce	Embedding effective governance and partnerships		
	✓	✓	✓	✓	✓		
Link to Health and Care Standards ***(please ✓)***	Staying Healthy	Safe Care	Effective Care	Dignified Care	Timely Care	Individual Care	Staff and Resources
	✓	✓	✓	✓	✓	✓	✓

Quality, Safety and Patient Experience
The report outlines the good progress that was made in Quarter 1 2018/19 with delivering improvement against the Quality Priorities agreed in the Annual Plan 2018/19.
Financial Implications
The Health Board is off-track with delivering the financial plan at the end of Quarter 1 and remedial action plans are in place.
Legal Implications (including equality and diversity assessment)
None
Staffing Implications
None
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)
The monitoring report shows that we published our Area Plan and Wellbeing Plans in 2018/19.

Report History	**None**
Appendices	Appendix A – Quarter 1 Annual Plan 2018/19 Monitoring Report

Appendix B. Annual Plan Progress Report Qu2 2018/19 - GREEN ACTIONS

Actions and timescale						Impact Measurement	
Corporate Priority	Action		Timescale	Q2	Quarterly commentary on progress	Measure	Current position where numerical measures
Promoting and Enabling Healthier Communities Objectives Measures	M1	**Wellbeing and Area Plans in place**	Q1		Western Bay Area Plan agreed at Health Board in March 2018. Public Service Boards Wellbeing Plans and Plans for ICF have been agreed through an inclusive process.	Plans approved	
	M2	**Clinical Services Strategy Approved**	Q3		Clinical Redesign Groups finishing Nov 6th. Stakeholder engagement being initiated. Emerging priority scenarios in development. Alignment of Organisational Strategy & IMTP planning process complete. On track to be presented to Board for approval in January 2019.	Strategy approved	
	M3	**Organisational Strategy Approved**	Q3		Board agreement in principle of Organisational purpose; ambition; strategic aims and key themes for the Enabling Objectives. Stakeholder engagement being initiated aligned to Clinical Services plan and IMTP process. On track to be presented to Board for approval in January 2019.	Strategy approved	
Unscheduled Care Service Improvement Plan Actions	A1	Increase uptake of all childhood vaccinations. Local Public Health Team to support increased uptake in the following ways: Deliver immunisation awareness training for pre-school settings to promote key vaccination messages Contribute to the implementation of recommendations made in the "MMR Immunisation: process mapping of the child's journey" report Continue to promote the benefits of immunisation through Healthy Schools and Pre-Schools e-bulletins Develop local resources/ products to share good practice	Q1-Q4		Children's Immunisation Group (ChIG) to review terms of reference, workplan and reporting mechanisms to Strategic Immunisation Group (SIG). To continue to monitor data processes to ensure accuracy of data.This has been actioned and approved by SIG. Good progress in achieving targets.	Achieve minimum 90% uptake for childhood immunisations as measured by quarterly COVER stats in children aged 0-5yrs, aiming for 95% To achieve WG target of 55% vaccine uptake rates for those aged 6 months to 64yrs in an at risk group To achieve 45% uptake rate of the flu vaccine in children aged 2 and 3 years in Primary Care by March 2019 Aim for 90% uptake of MMR vaccination within teenage population Improve uptake of the MenACWY vaccine within primary care	% 3 doses of 5 in 1 by age 1= **95.2%** % MenB2 by age 1= **94.8%** % PCV2 by age 1= **95%** %Rotavirus by age 1= **94.6%** % MMR1 by age 2= **95.2%** %PCVf3 by age 2= **95.2%** % MenB4 by age 2= **94.8%** %Hib/MenC by age 2= **94.9%** % up to date in scheduled by age 4= **87.1%** % 2 doses of MMR by age 5= **91.2%** % 4 in 1 by age 5= **93.5%** % MMR by age 16= **92.5%** % teenage booster by age 16= **89.1%** %MenACWY by age 16= 90..6% *(all of the above are at June 2018)*
Stroke Service Improvement Plan Actions	A11	Continuing to improve on health literacy within the population as part of a preventative approach.	Q4		Health Literacy training organised for health professionals. The opportunity of a Health Literacy quality standard for pharmacies in Cwmtawe cluster currently being planned. Community assets/champions work programme being explored which is inclusive of health literacy, and higher level MECC and behaviour change facilitation skills. Training to take place November 2018. Scoping work for quality standard trial to be completed by end of November 2018.	Plan in place	
	A12	Use evidence based and behaviour change approaches including MECC to improve health and related outcomes.	Q4		Training sessions delivered with Health Visitor groups focusing on healthy weight, Swansea Council on Swansea PSB ageing well project and Employee wellbeing champions E-learning module being promoted to HB staff through intranet pages and made available on ESR. Further training sessions being planned to include train the trainer.	Training materials developed and tested.	

Actions and timescale						Impact Measurement	
Corporate Priority	**Action**		**Timescale**	**Q2**	**Quarterly commentary on progress**	**Measure**	**Current position where numerical measures**
Cancer Service Improvement Plan Actions	A15	Capacity and Demand work to be undertaken in Endoscopy and Pathology Services in preparation for the introduction of FIT testing from early 2019.	Q3		As part of the preparation for the implementation of the Single Cancer Pathway in April 2019, a full demand and capacity profiling exercise of USC, Urgent and Routine work has been undertaken for the Endoscopy service delivered via the NPTH, Singleton and Morriston units looking at delivery of bronchoscopies, gastroscopies, colonoscopies, flexible sigmoidoscopies or any dual combination of the previously mentioned procedures within those units. A prototype live queue dashboard has been developed and verified. We are in the process of working with Informatics colleagues to activate the live version in due course.	Reduce USC and NUSC referral rates.	Average number of USC referrals received a week between April September 2017 is 720 compared with a weekly average of 770 referrals in April to September 2018
	A18	Head and Neck services to continue actively promoting Human Papilloma Virus vaccination for boys in Wales.	Q1-4		In August 2018 the Cabinet Secretary for Health and Social Services announced the extension of the HPV vaccination programme to boys in Wales. This will build on the significant reductions in HPV-related disease which have already been seen as a result of the girls vaccination programme. In the longer term, alongside cervical screening programmes, it is expected to save lives from cervical cancer in women and HPV related cancers in both women and men.	Reduce referral rates	
HCAIs Service Improvement Plan Actions	A19	Promoting Water Keeps you Well campaign in primary care.	Q1		Hydration has been promoted in presentations to care homes as part of The Big Fight campaign. Hydration has been included in a presentation to be delivered to staff in secondary care. Campaign was launched in March 2018 by Public Health Wales.	% reduction in Co-Amoxiclav usage across the Health Board in 2017/18 baseline. % reduction in acid suppressant usage across Health Board on 2017/18 baseline.	
	A20	Adopt All Wales Urinary Catheter Passport.	Q2		This has been implemented across the Health Board at the end of Q1. • Bi-monthly audit indicates good adherence with restrictive policy and reduction in Co-amoxiclav usage. • It is acknowledged that the reduction in the use of Co-amoxiclav will result in an increase in overall antibiotic usage, as measured by Defined Daily Doses per 1000 Admissions (DDD/1000 AD), as alternative antibiotics are prescribed in place of Co-amoxiclav. This will impact on the Health Board's performance in relation to reduction in total antibiotic usage, but the risk posed by Co-amoxiclav in relation to C. difficile is a mitigating factor.		
	A21	Develop and implement restrictive antibiotic policy.	Q1		Implemented at the end of Quarter 1. • Bi-monthly audit indicates good adherence with restrictive policy and reduction in Co-amoxiclav usage. • It is acknowledged that the reduction in the use of Co-amoxiclav will result in an increase in overall antibiotic usage, as measured by Defined Daily Doses per 1000 Admissions (DDD/1000 AD), as alternative antibiotics are prescribed in place of Co-amoxiclav. This will impact on the Health Board's performance in relation to reduction in total antibiotic usage, but the risk posed by Co-amoxiclav in relation to C. difficile is a mitigating factor.		
	A22	Audit & feedback of antimicrobial usage.	Q1		Bi-monthly audits will continue, with feedback to enable Delivery Units to monitor and improve performance.		
	M7	**Reduce harm from falls**	Q1-4		In quarter 2 the total number of falls was 918, of this number 395 resulted in harm. This is a decrease from quarter 1 when 1030 falls were reported of which 359 caused harm. • Comparing the 6 monthly figures of 2017/18 and 2018/19, 810 falls with harm were reported in 2017/18 and 754 in 2018/19. This shows a 7% decrease in falls causing harm compared to the same 6-month period last year.	Reduction in number of falls on 2017/18 baseline - from Quality Dashboard	13% reduction in falls (Q2 18/19= 918 compared with Q2 17/18= 1,056)
	M13	**The percentage of emergency responses to red calls arriving within (up to and including) 8 minutes**	Q1-4		Health Board Category A performance was 78% in June 2018 which exceeds the National target of 65%.	NHS Wales Outcomes Measures	78%

Actions and timescale						Impact Measurement	
Corporate Priority	Action		Timescale	Q2	Quarterly commentary on progress	Measure	Current position where numerical measures
Delivering Excellent Patient Outcomes, Experience and Access Objective Measures	M15	**Direct admission to Acute Stroke Unit (<4 hrs)**	Q1-4		Whilst there has been an improvement in admission to an acute bed in Morriston – pressures at the Princess of Wales have not improved. The actions that we have taken to address this has included support from the NHS Wales Delivery Unit. Following the recommendations raised in their report, Task and Finish Groups have been held and are ongoing to address the admission, flow and discharge processes to improve their compliance against this standard. This is clearly a difficult task when faced with unscheduled care pressures but it is one which we acknowledge needs to improve and our Delivery Unit teams are working hard to improve their performance in this area. The position has improved in Morriston and the actions taken to appoint additional middle tier medical staff (albeit there remains a constant vacancy pressure to cover) to provide increased out of hours cover will assist in managing patients into appropriate beds.	NHS Wales Outcomes Measures	54%
	M16	**CT Scan (<1 hrs)**			Clinicians had been informed in 2016 by the Delivery Unit that the 1 hour CT turn around was only being monitored and SSNAP reporting indicates this for information only. CT scans within 1 hour is currently not agreed locally for all strokes - this will need to be agreed with our radiology department with a review of their resources. We currently aim to undertake a CT within 1 hour for the thrombolysis calls alone, the remaining patients are falling under the RCP guidance of CT in <12 hours (which you will note compliance is mainly achieved) but would hope to scan everyone ASAP and within 1 hour if possible.		48.00%
	M25	**Achievement of C.Difficile trajectory (15 % reduction)**	Q1-4		At the end of Quarter 2, the cumulative number of C. difficile cases was 112, 15 cases less than the IMTP profile, and approximately 25% fewer cases compared with the same period in 2017/18.	NHS Wales Outcomes Measures	25% reduction (Q2 18/19= 112 compared with Q2 17/18= 150)
	M27	**Achievement of E.coli bacteraemia trajectory (5% reduction)**			At the end of Quarter 2, the cumulative number of cases of E. coli bacteraemia was 272, 16 cases above the IMTP profile, but approx. 5% fewer cases than in the same period in 2017/18.		5% reduction (Q2 18/19= 272 compared with Q2 18/19= 287)
	A24	Maximise use of 111 model	Q1-Q4		111 is fully utilised across ABMU Health Board. Since its inception in October 2016 the service has answered 291,502 calls with a mean answer time of 1 minute 30 seconds.	Reduce healthcare, professional and Amber 2 ambulance conveyances to hospital from 2017/18 baseline	
	A27	Maximise impact of Community Resource Teams and community rapid response models on patient flow	Q2		This is part of the ABMU Winter Plan for 2018/19. ABMU has an integrated Frequent Flyers Service for Swansea City with acute, community, social care and third sector involvement who also link with Community Resource Teams. This supports the collaborative approach across units and agencies. The group identifies patients whose needs are increasingly accessing the Emergency department. For 2018/19 this arrangement is being developed further to identify a wider cohort of patients across the wider system.	Achieve Western Bay programme measures for admission avoidance Complete review of investment in intermediate care and CRTs to maximise return on investment	
	A28	Reinvest resources from anticipatory care planning into community nursing teams	Q2		This is part of the ABMU Winter Plan for 2018/19. ACP has been implemented across Clusters and Community Resource teams.	Reinvestment completed and technical efficiencies released (£0.5m)	
	A31	Implement joint Wales Ambulance Services NHS Trust (WAST) / Health Board initiatives outlined in Appendix 10	Q3		The joint work programme between WAST and the HB continues to be implemented – focussing on a reduction in HCP calls. • There has been a 14% reduction in HCP (green) patient conveyances to hospital in the 9 month period between January and September 2018, when compared with the same period in 2017.	Reduce conveyances to hospital for non-acute the 'Big 5' conditions against the 2017/18 baseline.	Green (HCP) calls have reduced by 24% when compared to Q2 of last year. Amber calls have increased by 2%.

Actions and timescale						Impact Measurement	
Corporate Priority	Action		Timescale	Q2	Quarterly commentary on progress	Measure	Current position where numerical measures
Unscheduled Care Service Improvement Plan Actions	A32	Implement revised falls pathway across the Health Board	Q1-Q4		Ongoing refresher training of care home staff on the i-Stumble version 1 tool across the 3 local authorities to improve the management of patients who have fallen but who have not incurred any physical injury. • I stumble version 2 had been approved and will be rolled out for trial implementation in the Pobl homes in NPT and in 4 local authority residential homes in Swansea. Training is planned to start with one home in NPT from November and will be rolled out to the remaining homes between December and January. Using this tool will support a reduction in risk of pressure damage for 'long lie' residents awaiting a lower acuity ambulance response.	Reduce conveyances for non-injured fall patients against 2017/18 baseline.	
	A33	Continue to develop ambulatory care models across the Health Board.	Q2		Ongoing implementation of models that support ambulatory care within existing resources continued in Quarter 2. Plans for Quarter 3 include: • Extending the medical day unit hours at Singleton from October between 8.00am and 8.00pm to divert appropriate patients from the front door. • Reviewing 3 ambulatory care pathways in Singleton – DVT,PE and pregnancy. • Introducing fast track referral pathway for post operative complication patients at Morriston. • Maximising the day unit at NPT hospital • Launching hot clinics in 3 new specialities in Morriston	25% of acute medical admissions to be managed through an AEC pathway - measures in development.	
	A35	Psychiatric liaison service measures to be introduced.	Q1-Q4		Performance measures for response to referral introduced: • 1 hour response time for ED referrals • 4 hour urgent referrals • 72 hours ward referrals • Regular reporting on performance implemented. • Resources allocated to extend hours of services operation at weekends. Now 7 day service, 8am to 10pm. • Recruitment live.	98% compliance with 1 hour response time from referral to assessment for psychiatric liaison services. Reduction in numbers of frequent mental health attenders on 2017/18 baseline.	
	A37	Implement ECIP plan within resources at Morriston	Q2		The USC improvement programme for Morriston reflects the recommendations from ECIP.	Contribution to achievement of HB target for 4 hour waits on site.	68.80%
	A38	Implement ECIP plan within resources at POWH.	Q1		The USC improvement programme for Princess of Wales hospital reflects the recommendations from ECIP The report from the NHS Elect plan has informed actions developed and implemented in Q1 and also going into future periods. Examples such as AESU (Q1) and frailty at the front door (Q2) came from this work. POWH ED implemented a "Minors in May" initiative which resulted in minors 4hr performance improving from 90.32% (225 breaches) to 97.55% (68 breaches) at the end of Q1. Minors stream vulnerability in evenings/overnight and during times of significant crowding within the ED.	Contribution to achievement of HB target for 4 hour waits on site.	74.50%
	A40	Consistently implement SAFER flow bundle on all wards as a Quality Priority.	Q1		The implementation and roll out of the SAFER flow principles remains a key element of our USC improvement plan and is overseen by the USC delivery board. There is evidence of wards where there is exemplar practice in the application of the SAFER process, however there remains inconsistency in relation to wholesale implementation. • The Health Board is working towards the implementation of the discharge improvement plan developed in response to WAO discharge report. The findings from the DU complex discharge audit have recently been received and the HB is currently reviewing its discharge improvement priorities as a result.	35% of patients discharged home before lunch. 100% of inpatients have an estimated Date of Discharge. Compliance with other metrics measured through the Patient Flow Workstream.	
	A42	Implement measures for mental health services to general wards	Q1		The liaison service continues to prioritise referrals for AMAU to support older adult patients with cognitive impairment to prevent admission to acute general wards and aim for patient to return to their own home. • Liaison support workers work with identified patients and support them during their admission.	Improvement in compliance with same day assessment by psychiatric liaison team on 2017/18 baseline. Reduction in numbers of patients on general wards awaiting a MH bed.	

Actions and timescale						Impact Measurement	
Corporate Priority	**Action**		**Timescale**	**Q2**	**Quarterly commentary on progress**	**Measure**	**Current position where numerical measures**
	A43	Implement comprehensive geriatric assessment for all patients >75 years (Quality Priority)	Q1		The original plans to enhance and develop frailty models during the year within existing resources have been largely been implemented. This includes the following services: o TOCALs into Neath Port Talbot Hospital o The full implementation of the multi disciplinary older persons service at Singleton hospital (ICOP) o Embedding the redesigned frailty model at PoW. This includes enhancing senior clinician presence at the front door of the hospital from November. o Implementation of the older persons assessment service at the front door of Morriston hospital. • The intermediate care consultants all proactively undertake CGA's.	95% of patients over 75 years to have a CGA - measure sin development.	
	A44	Implement measures for the new Western Bay discharge standards.	Q2-4		Discharge standards now in place. New audit tool to assess against the standards is being evaluated.	Compliance with the measures	
	A47	Develop early supported discharge rehabilitation model	Q2		ESD for COPD supported by IBG and being rolled out. ESD for stroke being developed as a joint proposal between Morriston and Singleton units. Discharge to Assess model also in development. ESD for Older People pilot started in NPT in late September - results to be evaluated in December.	Model developed	
	A48	Implement Service Remodelling programme in acute hospitals	Q2		• Frailty at the Front Door models developed on all three main hospital sites • ESD for COPD being rolled out across the Health Board • Innovative enabling ward in place at NPTH • Continuing focus on SAFER flow bundle • Ongoing improvements in rehab pathways and pull through to community hospitals • Public engagement undertaken on Tranche 1 and Board decision made to proceed with additional bed closure on a phased basis • 106 adult non-mental health beds (acute and community hospitals) beds closed over the last 18 months • Monthly evaluation of system impacts through Service Remodelling Workstream Group • Joint Evaluation Group with partners established - first meeting 30th November • Bed Utilisation Survey undertaken on 3rd October - results will be presented to Executive Team on 28th November.	Service remodelling schemes implemented in line with financial plan.	
Stroke Service Improvement Plan Actions	A50	Confirm thrombectomy pathway for ABMUHB residents	Q1		• This will be a commissioned service by WHSCC from the 1st April 2019 – currently local arrangements are in place and dealt with on a patient by patient basis.	Pathway in place.	
	A51	Promote FAST in the identification of strokes	Q1-Q4		Continuing to support National work / communications.	N/A	
Planned Care Service Improvement Plan Actions	A57	Roll out and develop use of E-Referrals.	Q1-Q4		98% of e-referrals are now prioritised electronically	All referrals submitted through e-referral route.	98% of e-referrals are prioritised electronically
	A65	Develop Theatre Efficiency Board role in improving performance across sites.	Q1-4		Theatre Effeciancy Board set up with Terms of Reference and Multi Disciplinary forum. • Local Delivery Units also have theatre committees to take forward local actions. • Information and performance measures are being reviewed.	Challenging Performance and building best evidence base line performance measures.	
	A70	Clear full year capacity plans in place to deliver agreed year end position.	Q1		RTT capacity plans are in place which delivers the health board year end profile of 2,664 for patients waiting over 36 weeks and Nil for patients waiting over 26 weeks for a first outpatient appointment. Delivery against the plans are monitored and challenged on a weekly basis.	Signed off plans in place. Resources agreed. Accountability letters issued.	

Actions and timescale						Impact Measurement	
Corporate Priority	Action		Timescale	Q2	Quarterly commentary on progress	Measure	Current position where numerical measures
	A76	To support symptom awareness campaigns, collaborate with Primary Care to make available risk assessment tools, training materials and provide access to specialist support.	Q2		ABMU HB's Macmillan GP Facilitator (Dr Jenny Brick) has been doing work to improve earlier diagnosis in ABMU.This has been mainly educational for GPs and includes lectures at the Protected Time for Learning for the clusters as well as lunch-time clinical sessions. Dr Brick has been highlighting the latest evidence with regard to thrombocytosis as a possible cancer marker and making GPs aware of the ABMU CXR direct to CT pathway. Improved patient awareness of the pathway has been through use of the leaflet 'Had a test- need another' when GPs give the CXR request form to patients. Collaborative working with the radiology Department has meant that the same information is now given when patients arrive at x-ray reception through laminated information sheets and posters.	Reduced number of patients diagnosed in an emergency setting. Improved screening uptake. Reducing the proportion of patients referred who will actually be found not to have cancer.	
	A77	Using CAPITA report and benchmarking information implement demand/capacity plans for endoscopy and gastroenterology.	Q2		The Cancer Information and Improvement team has built on the work undertaken by CAPITA last year and undertaken a full capacity review of the following parts of the pathway: • A full demand and capacity profiling exercise of USC, Urgent and Routine work has been undertaken for the Endoscopy service delivered via the NPTH, Singleton and Morriston units looking at delivery of bronchoscopies, gastroscopies, colonoscopies, flexible sigmoidoscopies or any dual combination of the previously mentioned procedureswithin those units. • A prototype live queue dashboard has been developed and verified. We are in the process of working with Informatics colleagues to activate the live version in due course.		
	A78	Profiling endoscopy, imaging and pathology demand to ensure sufficient capacity is in place to support compliance with cancer waiting times and the introduction of the single cancer pathway.`	Q2-4		As above for endoscopy and pathology • The Health board is in the process of moving to one radiology system across all of its sites. The East of the HB (Princess of Wales and Neath Port Talbot hospitals) has been using this system for some time. The west of the HB will be moving to the new Radis system on the 24th of November. • In preparation for this the Cancer Information and Improvement team has developed a prototype live dashboard view that will allow the user to access current queue information for all CT,MR and USS scans for all USC, Urgent and Routine scan requests received in the Health Board. • The prototype dashboard and accompanying stock and flow models have already been built and are currently entering the verification phase of testing ahead of a live click view dashboard being made available. The dashboard will allow users to actively manage queue length and the outputs from the dashboard will be used to power models of the system which will allow us to ensure we have enough capacity available to complete the diagnostic phase of the new single cancer pathway.	Reduced number of patients diagnosed in an emergency setting. Improved screening uptake. Reducing the proportion of patients	

Actions and timescale						Impact Measurement	
Corporate Priority	Action		Timescale	Q2	Quarterly commentary on progress	Measure	Current position where numerical measures
	A79	Expansion of Rapid Diagnostic Centre (RDC) service - increase clinics and GP clusters to 4.	Q2		ABMU HB successfully secured funding via the Wales Cancer Network to develop and deliver a 2 year pilot based on the Rapid Diagnostic Clinic concept. Funding was made available from April 2017 and the first patients were seen in June 2017. Based on the 12 month outcome data, the initial results from the RDC pilot is very encouraging . The data reports 83 clinics held and 228 patients seen (128 female and 112 male) with the average age being 69.4 years old. Preliminary results also suggest that the RDC model supports the single cancer pathway 28 day diagnostic metric, delivering a (non-histological) diagnosis on average within 4.4 days based on indicative ABMU data. Despite the roll out of a novel clinic model, the outcome data with a 10.5% conversion rate for the clinic is extremely positive with evidence of a good patient and referrer experience. Despite the increasing referrals, as a result of excellent engagement and communication between primary and secondary care the conversion rate suggests that the system must trust the GP instinct and the service has not been flooded to date. Currently, the greatest risk to the pilot is the cessation of WCN funding in March 2019. There is uncertainty within the pilot regarding the continuity of fixed term contracts beyond the end of the pilot phase, risking staff turnover and potential closure of the RDC at the end of the financial year. A business case has been submitted internally.	referred who will actually be found not to have cancer. USC patients having 1st OPA within 14 calendar days and diagnostics being undertaken within 10 days.	
	A82	Review the performance and the pathways in PoW Urology services, in line with All Wales peers.	Q2		• TRUS and Template biopsy waits - A review of the pathway where patients undergo multiple biopsy attempts has been undertaken to clarify where patients are no longer 'USC' and under a follow up protocol. New process agreed and implemented. • Demand and Capacity modelling work has been undertaken for Urology Outpatients and available to use via the Cancer Dashboard		
	A83	Revise Post-Menopausal Bleeding pathway.	Q2		The Singleton Delivery Unit is working towards moving from a 3 days a week to a 5 day a week PMB service, however this requires the support of POW consultants where consultant staffing is an issue.		
	A85	MyoSure activity to be introduced to Singleton and Neath	Q3		One-stop diagnostic model for postmenopausal bleeding and pelvic masses implemented		
	A86	Cancer improvement Board to focus on immediate performance issues as well as sustainable improvement breast, gynaecology and urology.	Q1		Cancer Improvement Board established and Terms of Reference agreed. Performance is a continuous agenda item. Meetings are held on a monthly basis.	As line 93	
	A87	Support and Challenge Panels to evolve to ensure constructive challenge; update and support to each MDT.	Q1		Support and Challenge panels continue to be scheduled and held between the MDT Leads and the Health Board Cancer Lead Clinician and Cancer Quality & Standards Manager.		
	A88	Action plans to improve Cancer Performance to be delivered by each Unit at tumour site level in 30, 60, 90 day view.	Q1		Delivery Unit Recovery Plans are in place and continue to be monitored and reviewed at the monthly Cancer Improvement Board.		
Cancer Service Improvement Plan Actions	A89	Recommendations following the MDT review to be implemented and audited.	Q2		Recommendations from MDT assessments are discussed with the MDT Lead and relevant management teams at the Support & Challenge Panels. • Peer review provides assurance to the Health Board regarding the quality of care being provided and recommendations for the MDT cancer teams as to aspects of the service that are of particularly high quality worthy of sharing with others and those aspects of care that could be improved. In cases of serious concerns or immediate risks in terms of service quality and/or patient safety specific notifications are made to Health Boards and to Healthcare Inspectorate Wales.		
	A95	Continue participation in the cancer peer review programme 2018/19 - Gynaecology; Thyroid; Breast; Sarcoma; skin; Acute Oncology and Teenage, young adults and infants.	Q1-4		The Health Board has fully engaged with the peer review process since its implementation. We have recently participated in the second cycle review for Breast Services and the first cycle for Thyroid, and for Acute Oncology Services, which is considered to be an important aspect of quality cancer services, both in terms of prevention and early diagnosis together with surveillance, rehabilitation and survivorship initiatives. Each site-specific service has developed an action plan to address the concerns raised in the outcome reports. These are monitored by the Cancer Improvement Board. Peer Review has been a positive experience. It has provided an opportunity for clinical and management teams to address adverse findings with a prudent approach, reviewing services together to resolve quality and safety issues where identified and work to maintain, improve and transform services as needed.		

Actions and timescale						Impact Measurement	
Corporate Priority	Action		Timescale	Q2	Quarterly commentary on progress	Measure	Current position where numerical measures
	A97	Deliver on peer review action plans, within resources.	Q1-4		• Action plans reviewed and monitored via the Cancer Improvement Board. • Outstanding actions reviewed at the October Cancer Improvement Board. • Common themes to be addressed include the Acute Oncology Service provision at Princess of Wales Delivery Unit, single handed surgeons, oncology provision, holistic need assessments and governance arrangements for the regional MDT's.		
	A99	Review of order of lung diagnostics and need to return to MDT for discussion post-test (esp CPEX and CT Guided biopsy).	Q2		A Macmillan Quality Improvement Manager was appointed at the beginning of September and has begun to review the lung cancer pathway in ABMU HB and will be establishing a joint collaborative with Hywel Dda for tertiary lung services following appointment of a Macmillan QI Manager at Hywel Dda.		
	A103	Appointment of HB Cancer Strategic Transformation Lead Nurse.	Q1		The Macmillan Strategic Lead Cancer Nurse commenced in post on the 1st October 2018	Measure patient satisfaction through Patient Satisfaction Surveys	
	A109	To further develop the Cancer Dashboard, to allow Units to self-service cancer information to assist with their planning and performance management.	Q2		Through collaborative work undertaken by Cancer Information & Improvement and Information the CIIP was developed. Two separate views are available for USC and NUSC patients respectively to aid tracking and monitoring of patients progressing through either pathway. This visual interface of both views have been developed using information collated and input into Tracker 7. It allows the user to drill down to individual patient level, identifying the target date, current stage within the pathway and date of their next appointment. Prior to the existence of the dashboard, an excel spreadsheet was produced on a weekly basis by the Cancer Information team and distributed to the delivery units within the Health Board. The dashboard updates on an hourly basis and dramatically improve the timeliness information availability from up to seven days old to a maximum of an hour old. The system aids the user to identify where the main bottlenecks are within each of the main cancer pathways. It has been used to inform areas of future work and will serve as the feedback loop for any changes made to any of the active pathways going forward.		
	A112	Cancer Audit participation.	Q1-Q4		Cancer Improvement Team audits are currently being undertaken on Lung and Lower Gastrointestinal Cancer pathways against the National Optimal Pathways. Each ABMU cancer MDT has an annual audit programme, the outcomes of which are presented at their business meetings. National audit data collection is hampered by CaNISC functionality issues, as well as lack of easy access to our own data from silo systems within the ABMU data repository.	Compliance against the Cancer Information Framework. Audit outcomes.	

Actions and timescale						Impact Measurement	
Corporate Priority	**Action**		**Timescale**	**Q2**	**Quarterly commentary on progress**	**Measure**	**Current position where numerical measures**
	A113	Opening high-quality trials including radiotherapy and surgical trials.	Q1-Q4		Funding from Welsh Government through Health and Care Research Wales continues supporting a dedicated cancer research delivery team working together with research active clinicians. • The portfolio of research trials available in the Cancer Centre remains strong. Surgical cancer trials are successfully recruiting to target. There is also an increase in planned radiotherapy trials due to open in the next quarter. • A strong portfolio of Commercial trials in the Urology and Melanoma setting continues to contribute to income generation • Research delivery staff continue to be productive members of MDT's • Research delivery staff continue to have a presence on the student nurse curriculum. Student nurses have spoke placements in the Cancer trials unit • The Research Strategy for radiotherapy has been launched and regular radiotherapy research working group meetings have been established quarterly. • Phase 1 research clinic commenced September 2018 - Funding has been received from the Wales Cancer Research centre to support a Phase 1 clinic at the Cancer Centre . This will enable cancer patients from West Wales to have initial treatment discussions relating to early phase trials closer to home. This is in partnership with Velindre Early Phase Unit		
HCAI Service Improvement Plan Actions	A120	Establish a programme of peer review hand hygiene audits across specialty groups within Delivery Units.	Q1		Average hand hygiene compliance for Quarter 2 – 97%. • Delivery Units commenced peer review programme.	10% reduction in Staph aureus bacteraemia; data to be reported for each Delivery Unit by hospital acquired cases and community acquired cases (as identified through localised surveillance). % reduction in secondary care inpatients with PVC's on baseline in 2017/18 point prevalence survey.	Metrics show hand hygiene compliance 95- 97% (Jul-Sep)
	A121	Audit and feedback of MRSA Clinical Risk Assessment, & implementation of audit actions.	Q2		Audit undertaken as part of localised surveillance; compliance with Clinical Risk Assessment remains variable.		
	A122	Education on revised decolonisation protocol. Consider decolonisation treatment for patients requiring repeated vascular access, e.g. dialysis, chemotherapy, haematology patients.	Q2		Education programme delivered to all wards and units on secondary care sites during Quarter 2.		
	A124	Hand hygiene actions as above.	Q1		Average hand hygiene compliance for Quarter 2 – 97%. • Delivery Units commenced peer review programme.	Hand hygiene measures as above.	Metrics show hand hygiene compliance 95- 97% (Jul-Sep)
Delivery Plans	D9	Oral Health Delivery Plan	Q4				
	M30	**Theatre efficiency**	Q1-4		Actions ongoing	Achieve 90%	74% achieved at Morriston at end Q2
Demonstrating Value and Sustainability Objective Measures	M32	**New Ops - referrals**	Q1-4		The Annual Plan 2018/19 dentified a driver to reduce the volume of outpatient referrals through increased use of e-referral systems within individual GP practices, and clinicians providing advice and feedback. The Primary and Community Services Delivery Unit is leading this piece of work, supported by the Performance Improvement Manager, to move to 100% compliance with use of e-referral. • The 1% reduction in referrals target equates to 28,060 referrals per month. To the end of September 2018, performance is slightly below the target trajectory. • In 2017/18 58.15% (120,846) of GP referrals were received electronically, 41.85% (86,969) received via paper. • In 2018/19 99,069 GP referrals have been received during April – September, 63.2% (62,612 via Electronic) and 36.8% (36,457) via paper. • Work is being led by the Performance Improvement Manager, working with the GP cluster leads, to explore patterns of primary care referrals and opportunities to increase the utilisation of electronic referrals.	Achieve 1% reduction on 2017/18 eoy baseline	7% reduction (Sep-18= 15,896, Sep-17 =17,066)

Actions and timescale						Impact Measurement	
Corporate Priority	**Action**		**Timescale**	**Q2**	**Quarterly commentary on progress**	**Measure**	**Current position where numerical measures**
Securing and Fully Engaged and Skilled Workforce Objective Measures	M37	**Reduce turnover within the first 12 months of employment**	Q1-4		• The data shows particular decreases within Additional Clinical Services and our Nursing and Midwifery staff groups, which is particularly helpful given the difficulty recruiting registered nurses. This improvement may have partly been facilitated due to the new Nursing and Midwifery strategy published in 2017 which placed a greater commitment to a providing clinical supervision for newly qualified nurses. Furthermore, there has been a commitment to complete exit interviews for leavers in the first 12 months of employment to ensure detrimental themes are addressed. • Whilst there has been an increase in A&C leavers in the last quarter this is consistent with an increase in the same period last year. Medical and Dental has also seen a big increase in the last quarter which is due to rotation.	Reduce from eoy 2017/18 baseline	Overall Turnover has reduced over the last 5 months and remains close to 8% (FTE).
Stroke Service Improvement Plan Actions	A128	Recruitment to 2nd SPR in Morriston to support 4 hour bundle.	Q2		6 additional middle tier medical staff have been appointed at Morriston.	SpR appointed	
HCAI Service Improvement Plan Actions	A134	Antimicrobial stewardship training across the Health Board.	Q1		Antimicrobial stewardship training sessions provided on junior doctor induction by antimicrobial pharmacists; other sessions provided when requested.	Training rolled out.	
Planned Care Service Improvement Plan Actions	A136	Agree joint outsourcing package and implement commissioning of the activity agreed LTA in place for both organisations as a commissioner.	Q1-4 Q1-4		Outsourcing package agreed in line with Service Delivery Units RTT delivery plans for Q3/4. • Formal procurement exercise undertaken and contracts with successful private providers have been awarded. • Outsourcing has commenced and will continue to the end of March 2019.	Contracts in place Commission of activity underway.	
	A137	Agreed LTA in place for both organisations as a commissioner.	Q1		Signed LTAs in place across all South Wales Health Boards as both Providers and Commissioners	Signed agreed documents	

Corporate Priority		Action	Timescale	Actions and timescale: Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Mitigating Action for Q4 if Amber or Red	Impact Measurement: Measure	Current position where numerical measures available	Responsibility and Accountability: Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance	Lead
Corporate Objective 1 - Promoting and Enabling Healthier Communities																	
Promoting and Enabling Healthier Communities Objectives Measures	M1	**Wellbeing and Area Plans in place**	Q1					Western Bay Area Plan agreed at Health Board in March 2018. Public Service Boards Wellbeing Plans and Plans for ICF have been agreed through an inclusive process.		Plans approved		DoS	Western Bay RPB	Asst DoS	Planning, Commissioning and Strategy Group	Board	**Jo Abbott Davies**
	M2	**Clinical Services Strategy Approved**	Q3					Clinical Senate Council preferred option shortlisted. Clinical engagement on-going. EIA in progress. Draft plan out for review. On track to be presented to Board for approval in January 2019.		Strategy approved		DoS		Head of Value and Strategy	Planning, Commissioning and Strategy Group	Board	**Kerry Broadhead**
	M3	**Organisational Strategy Approved**	Q3					Board sign off complete. Corporate Branding and launch arrangements in discussion.		Strategy approved		DoS		Head of Value and Strategy	Planning, Commissioning and Strategy Group	Board	**Kerry Broadhead**
Unscheduled Care Service Improvement Plan Actions	A1	Increase uptake of all childhood vaccinations. Local Public Health Team to support increased uptake in the following ways: Deliver immunisation awareness training for pre-school settings to promote key vaccination messages Contribute to the implementation of recommendations made in the "MMR Immunisation: process mapping of the child's journey" report Continue to promote the benefits of immunisation through Healthy Schools and Pre-Schools e-bulletins Develop local resources/ products to share good practice	Q1-Q4					Children's Immunisation Group (ChIG) to review terms of reference, work plan and reporting mechanisms to Strategic Immunisation Group (SIG). To continue to monitor data processes to ensure accuracy of data. This has been actioned and approved by SIG. Good progress in achieving targets.		Achieve minimum 90% uptake for childhood immunisations as measured by quarterly COVER stats in children aged 0-5yrs, aiming for 95% To achieve WG target of 55% vaccine uptake rates for those aged 6 months to 64yrs in an at risk group To achieve 45% uptake rate of the flu vaccine in children aged 2 and 3 years in Primary Care by March 2019 Aim for 90% uptake of MMR vaccination within teenage population Improve uptake of the MenACWY vaccine within primary care	**Position as at Q2:** % 3 doses of 6n 1 by age 1= 95.6% % MenB2 by age 1= 95.5% % PCV2 by age 1= 95.6% %Rotavirus by age 1= 94.7% % MMR1 by age 2= 94% %PCV3 by age 2= 94% % MenB4 by age 2= 94.2% %Hib/MenC by age 2= 94.2% % up to date in scheduled by age 4= 86.3% % 2 doses of MMR by age 5= 90% % 4 in 1 by age 5= 92.6% % MMR 1 by age 16=93.1% % teenage booster by age 16= 88.3% %MenACWY by age 16= 89% *(all of the above are at Nov 2018)* *%Fluenz by Aged 2 = 42%* *% Fluenz at age 3 = 35.2%* *(As at December 2018)*	DPH	PCS DU/ Singleton DU	Lead Health Visitor	USC Service Improvement Board	P&F Committee	**Paula Davies**
	A2	Reduce prevalence of smoking for targeted population groups including: Patients with respiratory conditions and heart disease; pre-operative care; staff.	Q1					The tier 1 target for smokers attempting to quit, is set at 3.25% of the population and currently at ABMU we are currently at a rate of 1.7% data to November 2018. All cessation service continue to achieve the 40% WG target of CO validated 4 week quits during Q3 (except for one service in October. Insight research undertaken in Q2 has resulted in MECC training programme developed in Q3 of pharmacy counter staff and planned for delivery in Q4. a review of hospital in house smoking cessation services is currently discussing the future location and ABM Management of this service.	LPHT are looking at the options to progress discussions around the management of ABM smoking cessation services (hospital and SSW) . Directors of PH Leadership Group have agreed that working together to reduce smoking prevalence is a priority and work to address implementation of the key components of the cessation system framework will start to be progressed in Q4. ABM LPHT are part of this Leadership Group.	Review of Tobacco Control against National Tobacco Delivery Plan Review of ABMUHB cessation services Achievement of HB trajectory for smoking cessation services.	% of adult smokers who make a quit attempt via smoking cessation services= 1.7% (Nov-18)	DPH	PCS DU / NPT DU	Principal Public Health Practitioner	USC Service Improvement Board	P&F Committee	**Liz Newbury Davies**
	A3	Increase flu immunisation uptake for people with chronic conditions and people over 65: - contribute to agreed actions / activities within the primary care flu action plan	Q3-Q4					At the end of December 2018 we are in a similar position with uptake of the influenza vaccine for those aged 65yrs and over in ABM in comparison to the previous season. Uptake rates are slightly above the Welsh average. Flu vaccination for all that are eligible will continue to be available until the end of March 2019. uptake of the influenza vaccine for those in an a risk group is slightly lower in comparison to the previous season, and is lower than the Welsh average. The Welsh average has also decreased in comparison to the previous season. ABM has exceed the WG target for diabetics and COPD, with lowest uptake noted in those who are morbidly obese. PHW have contacted NWIS on behalf of all Health Boards following concerns in the apparent inflation of the denominator figures for those in 'at risk groups' in Wales. GP's and community pharmacies are encouraged to work collaboratively with Community pharmacies reporting an increase in the number vaccinated so far. 11.097 vaccines were given by Community pharmacies by the end of December 2018. The increase in uptake has been largely attributed to off-site events, which has been initiated by the community pharmacies	Influenza vaccines will continue to be offered until the end of March 2019, so it is anticipated uptake rates will increase weekly. We await further information from NWIS regarding the apparent inflated denominator figures, which could result in a change in our % uptake within the 'at risk' groups.	Increase uptake to 55% from 45% Achieve WG target (75%) for individuals aged 65 years and over	% uptake of influenza among 65 year olds= 42.5% % uptake of influenza among under 65s in risk groups= 25.3%	DPH		Immunisation Coordinator	USC Service Improvement Board	P&F Committee	**Catherine Watts**
	A4	Improve access to dental care	Q4					ABMU continues to maintain its position as provider to the highest percentage of patients receiving dental care compared to all other Health boards and is significantly higher than the Welsh Average The latest data – March 2018 – confirms steady +0.5% increase in the total number of patients (adults and children)(who received NHS dental treatment in ABMU from the previous March: 3% more children, 0.5% more adults		Improve on 201718 baseline as measured through GDA statistics		COO	PCS DU	Head of Primary Care	USC Service Improvement Board	P&F Committee	**Lindsey Davies**
	A5	Improve primary care screening for chronic conditions	Q1-Q4					Development of an integrated diabetes model work continues through Cluster networks. Engagement of 6 Clusters (Bay, City, Cwmtawe, Llwchwr, Neath and Upper Valleys). Practice attendance planned for GPs and Practice Nurses, at , for bespoke educational training Jan - March. • North Cluster ICL CVD Risk Assessment Programme; delivered within 5/8 practices of North Cluster. • Pre-diabetes screening in 4 clusters. delivered within 3 practices of North Cluster to date.	Cluster Transformation Plans to include enhanced chronic conditions management based on Tower Hamlet approach.	Reduce variation practice to practice by Cluster Network		COO	PCS DU	IMTP Lead PCS	USC Service Improvement Board	P&F Committee	**Sam Paige, Sharon Miller**
	A6	Improve access to services to support mental wellbeing as part of the implementation plan for the Strategic Framework for Adult MH and the plans for new Health and Wellbeing Centres	Q4					Outline business case for Bridgend Wellness Centre submitted to WG in October.	Development of additional wellness centres in Swansea and Neath highlighted within planning cycle. Cluster Transformation proposals highlight the developments around social prescribing and community development which align well with Mental Health Strategy along with the development of 3rd sector services across a cluster based population	Measures TBC as part of the development of Health and Wellbeing Centres		DoS	ARCH Programme Board	Head of Service Planning - ARCH	USC Service Improvement Board	P&F Committee	**Karen Stapleton**
Stroke Service Improvement Plan Actions	A7	Implement the DOAC service	Q2					DOAC Local Enhanced Service commissioned from GP practices		Increase the number of patients on anti-coagulation therapy on 2017/18 baseline.		COO	PCS DU	IMTP Lead PCS	Stroke Service Improvement Board	P&F Committee	**Sharon Miller**
	A8	Smoking cessation (See USC plan)	Q4					See action A2		See USC plan		DPH					
	A9	Increasing levels of physical activity in key target groups, including staff	Q4					Physical Activity Alliance Group (PAAG) membership established in Q3 with 4 working Subgroups to meet in Q4. In Q3 Public Health Team have coordinated Healthy and Active Fund (Sports Wales) local bids and assisted with applications, monitoring and evaluation. Healthy and Active Fund project updates to be reported into group.		Action plan developed in response to Physical Activity Strategy.		DPH		Principal Public Health Practitioner	Stroke Service Improvement Board	P&F Committee	**Liz Newbury Davies**
	A10	Increasing proportion of population of a healthy weight.	Q4					Nutrition Skills for Life continue to support delivery of Foodwise Weight Management Programme by NERs and Community Groups. Support of School Holiday Enrichment Programme working in Partnership with Local authority Limited Weight Management Programmes delivery across HB continues. Continue promotion of Clusters to take forward Foodwise Weight Management Programme. Continue provision of Diabetes Structured Education. Provision of training to 1Mi 10 healthy steps	Obesity Pathway Review Workshop to be held as soon as possible to improve pathway with the HB	Obesity pathway review		DPH		Head of Nutrition and Dietetics	Stroke Service Improvement Board	P&F Committee	**Carol Milton**
	A11	Continuing to improve on health literacy within the population as part of a preventative approach.	Q4					Health Literacy communication skills training for health professionals delivered and report written up. The opportunity of a Health Literacy quality standard for pharmacies in Cwmtawe cluster currently being planned. Community assets/champions work programme being explored which is inclusive of health literacy, and higher level MECC and behaviour change facilitation skills.		Plan in place		DPH		Principal Public Health Practitioner	Stroke Service Improvement Board	P&F Committee	**Liz Newbury Davies**
	A12	Use evidence based and behaviour change approaches including MECC to improve health and related outcomes.	Q4					• Developed plan for sustainable approach to MECC in ABM area • Agreement gained to include information about MECC in Values Led Induction programme Staff Handbook • MECC Level 1 Brief Advice E learning module now available on ESR and is being promoted • Delivered training as part of Swansea PSB Ageing Well MECC Project to 18 people across a range of organisations • Behaviour change / MECC level 2 training and support provided to Health Visiting team (approx. 150 staff members between September and December 2018) • MECC Level 1 Brief Advice taster session delivered to around 100 Employee Wellbeing Champions at Autumn workshops, developing a MECC / Behaviour Change Level 2 train the trainer approach • MECC being embedded into Co-production Training Programme (Co-production Implementation Group) • Training materials and resources reviewed and updated • Case studies developed • Evaluation framework in place.		Training materials developed and tested.		DPH		Principal Public Health Practitioner	Stroke Service Improvement Board	P&F Committee	**Liz Newbury Davies**
	A13	Develop a proposal for BHF funding to support blood pressure reduction.	Q1					No information available		Proposal developed and considered by the BHF		COO		Assoc Director of R&S	Stroke Service Improvement Board	P&F Committee	**Jan Thomas**
Cancer Service Improvement Plan Actions	A14	Provide information verbally and non-verbally and Making Every Contact Count about what the risk factors for cancer are and how to reduce them - smoking, alcohol, obesity and physical activity.	Q1-4					See actions 1-A6		Achievement of Health Board trajectory for smoking cessation services.		DPH/COO					
	A15	Capacity and Demand work to be undertaken in Endoscopy and Pathology Services in preparation for the introduction of FIT testing from early 2019.	Q3					As part of the preparation for the implementation of the Single Cancer Pathway in April 2019, a full demand and capacity profiling exercise of USC, Urgent and Routine work has been undertaken for the Endoscopy service delivered via the NPTH, Singleton and Morriston units looking at delivery of bronchoscopies, gastroscopies, colonoscopies, flexible sigmoidoscopies or any dual combination of the previously mentioned procedures within those units. A prototype live queue dashboard has been developed and verified. We are in the process of working with Informatics colleagues to activate the live version in due course. D&C modelling of health board wide endoscopy services has been undertaken. A live queue and performance dashboard was made available for use in December 2018 for this area. The modelling work helped inform the shortfall in		Reduce USC and NUSC referral rates.	Average number of USC referrals received a month between April and December 2017 is 963 compared with a monthly average of 1,048 referrals in April to December 2018	COO		Cancer Quality and Standards Manager	Cancer Service Improvement Board	P&F Committee	**Mel Simmons**
	A16	Progress on tackling risk factors for cancer to be monitored and reported through the Public Health Outcomes framework by health boards and trusts.	Q1-4					See actions A1-A6				DPH					
	A17	Review ABMUHB smoking cessation services to align with National Tobacco Delivery Plan.	Q2					See action A2				DPH					
	A18	Head and Neck services to continue actively promoting Human Papilloma Virus vaccination for boys in Wales.	Q1-4					In August 2018 the Cabinet Secretary for Health and Social Services announced the extension of the HPV vaccination programme to boys in Wales The H&N MDT is actively promoting HPV vaccines for both boys and girls as part of core business. Action complete.	N/A	Reduce referral rates		COO		Cancer Quality and Standards Manager	Infection Control Committee	Q&S Committee	**Mel Simmons**
HCAIs Service Improvement Plan Actions	A19	Promoting Water Keeps you Well campaign in primary care.	Q1					Hydration has been promoted in presentations to care homes as part of The Big Fight campaign. Hydration has been included in a presentation to be delivered to staff in secondary care. Campaign was launched in March 2018 by Public Health Wales. The IPC Team has drafted a poster to promote increasing fluid intake using				DPH	PCS DU	Principal Public Health Practitioner	Infection Control Committee	Q&S Committee	**Delyth Davies / Janice Price**
	A20	Adopt All Wales Urinary Catheter Passport.	Q2					This has been implemented across the Health Board at the end of Q1. • Bi-monthly audit indicates good adherence with restrictive policy and reduction in Co-amoxiclav usage. • It is acknowledged that the reduction in the use of Co-amoxiclav will result in an increase in overall antibiotic usage, as measured by Defined Daily Doses per 1000 Admissions (DDD/1000 AD), as alternative antibiotics are prescribed in place of Co-amoxiclav. This will impact on the Health Board's performance in relation to reduction in total antibiotic usage, but the risk posed by Co-amoxiclav in relation to C. difficile is a mitigating factor.		% reduction in Co-Amoxiclav usage across the Health Board in 2017/18 baseline.		DPH/DoN		Lead Nurse - IPC	Infection Control Committee	Q&S Committee	**Delyth Davies / Janice Price**
	A21	Develop and implement restrictive antibiotic policy.	Q1					Implemented at the end of Quarter 1. • Bi-monthly audit indicates good adherence with restrictive policy and reduction in Co-amoxiclav usage. • It is acknowledged that the reduction in the use of Co-amoxiclav will result in an increase in overall antibiotic usage, as measured by Defined Daily Doses per 1000 Admissions (DDD/1000 AD), as alternative antibiotics are prescribed in place of Co-amoxiclav. This will impact on the Health Board's performance in relation to reduction in total antibiotic usage, but the risk posed by Co-amoxiclav in relation to C. difficile is a mitigating factor.		% reduction in acid suppressant usage across Health Board on 2017/18 baseline.		DPH/DoN		Lead Nurse - IPC	Infection Control Committee	Q&S Committee	**Delyth Davies / Janice Price**
	A22	Audit & feedback of antimicrobial usage.	Q1					Bi-monthly audits will continue, with feedback to enable Delivery Units to monitor and improve performance.				DPH/DoN		Lead Nurse - IPC	Infection Control Committee	Q&S Committee	**Delyth Davies / Janice Price**
	A23	Review pathways for patients with biliary tract disease (Simon Weaver - POW)	Q1									DPH	POW DU		Infection Control Committee	Q&S Committee	**Delyth**
Corporate Objective 2- Delivering Excellent Patient Outcomes, Experience and Access																	
	M4	**Refresh our Quality Strategy and approach to Quality Improvement**	Q4					On hold pending new DoN and MD advice	To be integrated into Clinical Services Plan	Quality Strategy approved		DoT		Head of Risk, Patient Experience	Q&S Committee	Quality and Safety Committee	**Cathy Dowling**
		Improvement against our Quality Priorities:															
	M5	**Improve SAFER Patient Flow**	Q1-4					•The implementation and roll out of the SAFER flow principles remains a key element of our USC improvement plan and is overseen by the USC delivery board. • The findings from the DU complex discharge audit confirmed that there is evidence of wards where there is exemplar practice in the application of the SAFER process, however there remains variation in relation to wholesale implementation.	A discharge workshop held on 14th January reaffirmed that SAFER remains a priority for the organisation and a clinically led group will be implemented to drive consistent implementation. Delivery unit progress will be monitored at quarterly performance reviews. Measures that monitor improvements in patient flow include: • The number and percentage of stranded patients • The percentage of patients discharged before midday • The number and percentage of patients who have an estimated date of discharge to inform their discharge planning arrangements. A revised HB patient flow policy will be completed this quarter which will reinforce SAFER as the framework for ensuring patient flow and safety.	Patient Flow metrics collected via Patient Flow Dashboard		COO	All DUs	Head of PE, Risk and Legal Services	USC Service Improvement Board	Q&S Committee	**Hazel Lloyd**
	M6	**Roll out Comprehensive Geriatric Assessment**						The Health Board has implemented a range of service changes to enhance and develop frailty models during the year within existing resources. • TOCALs service into Neath Port Talbot Hospital • The full implementation of the multi disciplinary older persons service at Singleton hospital (ICOP) • Embedding the redesigned frailty model at POW. This includes enhancing senior clinician presence at the front door of the hospital from November. • Implementation of the older persons assessment service (OPAS) at the front door of Morriston hospital. • The intermediate care consultants all proactively undertake CGA's.		Audit of patients in defined age group receiving CGA		COO	All DUs	Head of PE, Risk and Legal Services	USC Service Improvement Board	Q&S Committee	**Hazel Lloyd**
	M7	**Reduce harm from falls**						In quarter 2 the total number of falls was 918, of this number 395 resulted in harm. This is a decrease from quarter 1 when 1030 falls were reported of which 359 caused harm. • Comparing the 6 monthly figures of 2017/18 and 2018/19, 810 falls with harm were reported in 2017/18 and 754 in 2018/19. This shows a 7% decrease in falls causing harm compared to the same 6-month period last year.		Reduction in number of falls on 2017/18 baseline - from Quality Dashboard	13% reduction in falls (Q2 18/19= 918 compared with Q2 17/18= 1,056)	DoN	All DUs	Head of PE, Risk and Legal Services		Q&S Committee	**Hazel Lloyd**
		Improve outcomes following stroke						See Action No O16-O19		NHS Wales Outcomes Measures							
	M8	**Improve End of Life Care**						Clinical Lead for Advance Care Planning identified and developing team across HB. Increased use and recording of ACP and increased education across Paeds. Independent Review of palliative Care Services action plan developed. WG funding received to progress actions prioritised against EoLC Delivery Plan.		Metrics from the Quality Dashboard (TBC)		DoT	All DUs	Head of PE, Risk and Legal Services		Q&S Committee	**Christine / Cathy**
	M9	**Improve Surgical Outcomes** **1. National Emergency Laparotomy Audit** **2. Lower limb amputation for peripheral arterial disease** **3.Enhanced Recovery after Surgery**						Measures in development		1. NELA 2. National Vascular Registry Data 3. ERAS metrics		DoT	Exec Lead	Head of PE, Risk and Legal Services		Q&S Committee	**Christine / Cathy**

Corporate Priority		Action	Timescale	Progress Q1	Progress Q2	Progress Q3	Progress Q4	Quarterly commentary on progress	Mitigating Action for Q4 if Amber or Red	Impact Measurement: Measure	Impact Measurement: Current position where numerical measures available	Responsibility and Accountability: Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance	Lead
Delivering Excellent Patient Outcomes, Experience and Access Objective Measures	M10	**Reduce pressure ulcers**	Q1-4					As per the data sourced from the Datix dashboard on 16/01/2019 the current position for pressure ulcer development in Q2 is: 11% increase Q2 18/19 = 302 compared with Q2 17/18 = 270 The dashboard provides the most up to date data and is not static; it will change as the results of pressure ulcer investigation and scrutiny are updated on Datix.	Reduction in the number of pressure ulcers developing in ABMU led by the Pressure Ulcer prevention Strategic Group. There has been success in reducing the numbers of severe pressure ulcers developing which is indicative of earlier intervention to prevent deterioration of superficial ulceration. The report into the development of serious incident reported pressure ulcers, by Welsh Risk Pool, identifies that the predominant causal factor for avoidable PU development is inadequate frequency of repositioning. The recently published Pressure Ulcer Prevention and Management Policy clearly identifies the minimum requirements for repositioning patients at risk of pressure ulcers; and implementation of the policy is underway. A pressure ulcer grading audit undertaken in October 2018, by the TVN's, identified that 58% of Datix reports relating to pressure ulcers were incorrect; 39% of the reports recorded skin damage that was not a pressure ulcer. The findings have been informally reported to individual SDU's and the final report and recommendations are to be presented at the February PUPSG meeting. The number of pressure ulcers developing in POWH is significantly driving the increase in the total number of PU's recorded for Q2 2018/2019. POWH has seen a 35% increase :Q2 18/19 = 71 compared with Q2 17/18 = 46. The TVN post, vacant for 6 months, has recently been filled. There is a drive to increase the number of pressure ulcers scrutinised in community. Where the scrutiny panels are well established, there has been a decrease in avoidable pressure ulcers. The learning from each of the SDU scrutiny panels is collated in a report and shared at the PUPSG meetings.	Reduction on 2017/18 baseline through Quality Dashboard	23% increase in pressure ulcers Q2 18/19= 378 compared with Q2 17/18= 308	DoN	All DUs	Head of PE, Risk and Legal Services		Q&S Committee	Hazel Lloyd
		Reduce HCAIs						See Action No O26-O29		NHS Wales Outcomes Measures		DoN					
		Deliver the Targeted Intervention Priority Improvement Trajectories:															
		Unscheduled Care															
	M11	**The percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge**	Q1-4					December 2018 4 hour performance – 76.5% This is a 3.09% improvement compared with December 2017 but performance against this measure has not achieved the HB trajectory.	Full implementation of winter plans and unscheduled care improvement plans. Development of transformation bid to improve system capacity to enable timely discharge of patients from hospital (following the balance of care audit in October) Clinically led groups will be leading on improved adherence to SAFER flow principles and discharge process.	NHS Wales Outcomes Measures	76.49%	COO	MDU, POW DU	Asst COO	P&F Committee	P&F Committee	Jan Thomas
	M12	**The number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge**						December 2018 12 hour waits - 759 This is a 13% reduction compared with December 2017 but performance against this measure has not achieved the HB trajectory.	Full implementation of winter plans and unscheduled care improvement plans. Development of transformation bid to improve system capacity to enable timely discharge of patients from hospital (following the balance of care audit in October) Clinically led groups will be leading on improved adherence to SAFER flow principles and discharge process.		756	COO	MDU, POW DU	Asst COO	P&F Committee	P&F Committee	Jan Thomas
	M13	**The percentage of emergency responses to red calls arriving within (up to and including) 8 minutes**						Health Board Category A performance was 75.4% in December 2018 which exceeds the National target of 65%. Performance against this measure also exceeded the December 2017 response time by 6.4%.	Full implementation of winter plans and unscheduled care improvement plans. Development of transformation bid to improve system capacity to enable timely discharge of patients from hospital (following the balance of care audit in October) Clinically led groups will be leading on improved adherence to SAFER flow principles and discharge process.		75%	COO	MDU, POW DU	Asst COO	P&F Committee	P&F Committee	Jan Thomas
	M14	**Number of ambulance handovers over one hour**						>1 hour ambulance waits in December 2018 - 855. This is a 6.3%reduction when compared with December 2017, However performance against this measure has not achieved the internal trajectories set by the HB.	Full implementation of winter plans and unscheduled care improvement plans. Development of transformation bid to improve system capacity to enable timely discharge of patients from hospital (following the balance of care audit in October) Clinically led groups will be leading on improved adherence to SAFER flow principles and discharge process.		842	COO	MDU, POW DU	Asst COO	P&F Committee	P&F Committee	Jan Thomas
		Stroke Care															
	M15	**Direct admission to Acute Stroke Unit (<4 hrs)**	Q1-4					Whilst there has been an improvement in admission to an acute bed in Morriston – pressures at the Princess of Wales have not improved. The actions that we have taken to address this has included support from the NHS Wales Delivery Unit. Following the recommendations raised in their report, Task and Finish Groups have been held to address the admission, flow and discharge processes to improve their compliance against this standard. This is clearly a difficult task when faced with unscheduled care pressures but it is one which we acknowledge needs to improve and our Delivery Unit teams are working hard to improve their performance in this area. The position has improved in Morriston and the actions taken to appoint additional middle tier medical staff (albeit there remains a constant vacancy pressure to cover) to provide increased out of hours cover will assist in managing patients into appropriate beds.	The policy for the protection of acute Stroke beds need to be diligently followed and only in very rare exceptional circumstances should they be over ridden. Patients need to be followed through the pathway with transferred arranged to rehabilitation at pace.	NHS Wales Outcomes Measures	53.25%	COO	MDU, POW DU	Assoc Dir R&S	Stroke Service Improvement Board	P&F Committee	Malcolm Thomas
	M16	**CT Scan (<1 hrs)**						Clinicians had been informed in 2016 by the Delivery Unit that the 1 hour CT turn around was only being monitored and SSNAP reporting indicates this for information only. CT scans within 1 hour is currently not agreed locally for all strokes - this will need to be agreed with our radiology department with a review of their resources. We currently aim to undertake a CT within 1 hour for the thrombolysis calls alone, the remaining patients are falling under the RCP guidance of CT in <12 hours (which you will note compliance is mainly achieved) but would hope to scan everyone ASAP and within 1 hour if possible.	Meeting being arranged with Radiology and Stroke team to address pathway policy changes and to facilitate greater and more timely access to CT scanning provision.		48.72%	COO	MDU, POW DU	Assoc Dir R&S	Stroke Service Improvement Board	P&F Committee	Malcolm Thomas
	M17	**Assessed by a Stroke Specialist Consultant Physician (< 24 hrs)**						Consultant assessment at the Princess of Wales Hospital, which currently has only two full time Stroke Consultants and as a result – performance for the review within 24hrs is variable in periods of leave and sickness. The Consultants have recently agreed a new job plan with the Service Group to provide ward cover during periods of annual leave. However, there remains the outstanding pressure out of hours and at weekends with formal cover and responsibility for Stroke patient being reviewed by the medical duty teams. There is a similar pressure in Morriston with there being no formal Stroke Out of Hours rota – activity being covered by the Medical Team there also. However, the work within the Health Board around the development of a HASU has indicated within its minimum standards that there ought to be a dedicated 1:8 Stroke rota – and this will be explored further as part of the Business Case.	Morriston has seen improvements but unscheduled care pressures will continue to potentially compromise availability. HASU Business Case with a dedicated 1:8 consultant rota is the preferred model to address this target.		85.90%	COO	MDU, POW DU	Assoc Dir R&S	Stroke Service Improvement Board	P&F Committee	Malcolm Thomas
	M18	**Thrombolysis door to needle <= 45 mins**						Thrombolysis door to needle time has proven difficult – actions taken since August are the additional appointment of medical middle tier posts in Morriston to improve support to the A & E department and to improve access to timely thrombolysis – those eligible for thrombolysis receive the intervention in a timely way. The Units will be reviewed at the end of November as part of the all Wales thrombolysis review and recommendations from that process will be developed and actioned as appropriate	POW have good access. Morriston Clinical Fellows will need to respond to pressure of timely access out of hours (which is where the pressure point remains).		28.57%	COO	MDU, POW DU	Assoc Dir R&S	Stroke Service Improvement Board	P&F Committee	Malcolm Thomas
		Planned Care															
	M19	**The %age of patients waiting less than 26 weeks for treatment**	Q1-4					The 2018/19 percentage continues to improve from March 2018 and is at its highest position since November 2013. December 2018 reported 88% against the national 95% target.		NHS Wales Outcomes Measures	89.10%	COO	All acute DUs	Asst DoS	Planned Care Service Improvement Board	P&F Committee	Darren Griffiths
	M20	**The number of patients waiting more than 36 weeks for treatment**						In December 2018 there were 3,030 patients waiting over 36 weeks, therefore achieving the health board profile for quarter 3 of 3,045. Compared to 4,716 in December 2017, this is an improvement of 1,686 and the best position since June 2014. There was also an in-month reduction of 163 compared with November 2018. ENT, General Surgery, Plastic Surgery and Orthopaedics collectively account for 2,828 of the 3,030 over 36 weeks at December 2018. 99% of the patients waiting over 36 weeks are in the treatment stage of their pathway and Orthopaedics accounts for 66% of the breaches, followed by General Surgery with 16%.			3,030	COO	All acute DUs	Asst DoS	Planned Care Service Improvement Board	P&F Committee	Darren Griffiths
	M21	**The number of patients waiting more than 8 weeks for a specified diagnostic test**						• There were 693 patients waiting over 8 weeks for reportable diagnostics as at the end of December 2018. 82 breaches are for Non-Obstetric Ultrasounds (NOUS), 61 breaches are for MRIs and 6 breaches for Cystoscopy in Princess of Wales Hospital. The remaining 635 breaches are for the additional Cardiac tests which have been made reportable since April 2018. The reporting of additional tests is intended to provide insight into delays for specific tests that have an impact on overall Cardiac Referral to Treatment Times. The breakdown for patients waiting over 8 weeks for Cardiac Tests in June 2018 is as follows: • Diagnostic Angiography n 13			762 (123 Non Obstetric Ultrasounds, 4 Cystoscopy, 635 Cardiac tests),	COO	All acute DUs	Asst DoS	Planned Care Service Improvement Board	P&F Committee	Darren Griffiths
	M22	**The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date**						The health board did not deliver against its profile at the end of Q3 although a slight improvement on Q2. Unit plans are developed with progress being monitored against their profiles through the Outpatient Improvement Group. Additional funding has been released to support validation of the lists with a planned expectation that this exercise will eradicate c6000 erroneous entries through Q4.			66,269	COO	All acute DUs	Asst DoS	Planned Care Service Improvement Board	P&F Committee	Darren Griffiths
		Cancer															
	M23	**The percentage of patients newly diagnosed with cancer, not via the urgent route, that started definitive treatment within (up to and including) 31 days of diagnosis (regardless of referral route)**	Q1-4					Cancer performance delivery remains a significant concern and risk for the Health Board, which has been compounded as a result of specific service pressures in some of our high volume demand tumour sites; at Princess of Wales Hospital, Breast and Urology and Gynaecology in Swansea. • A HB trajectory has been planned for each Unit, based on updated activity and breaches from the previous 12 months. There has been more consistency in our performance since September , we have reported 96% compliance against the 31 day target. The top three tumour sites across the HB for breaches remain as Breast, Gynaecological and Urology. Concerns remain with the Urology Pathway with a significant number of patients in backlog. Breast services remain out of balance mainly due to gaps in service provision and the ability to match up breast radiology with Breast Surgeon activity. Demand and Capacity remains the issue for Gynaecology. The Unit have been unsuccessful in appointing into the 4th Gynae-Oncology Consultant post.	• New Consultant Oncologist appointed for Urology and Lung tumour sites. To commence in post March 2019. • Work to be completed by the end of January to allow the Urology single-handed template clinician to increase dedicated DSU weekly list • Chemotherapy Day Unit reviewing options for delivering some treatments outside of the day unit by utilising the Tenovus bus and possibly utilising chair facilities at Neath Port Talbot Delivery Unit. • New first outpatient OMFS pathway stage agreed and taken forward with Primary Care with a plan to commence in April. • New neck lump pathway agreed with a plan to implement at the end of January. • Cancer Improvement Team have developed Demand & Capacity analysis for first outpatient appointment across most specialties managing suspected cancer referrals; these will be developed into live dashboard views by Informatics with timeframes for this development to be determined	HB trajectory is 98% (WG target)	96%						Mel Simmons
	M24	**The percentage of patients newly diagnosed with cancer, via the urgent suspected cancer route, that started definitive treatment within (up to and including) 62 days receipt of referral**						Cancer performance delivery remains a significant concern and risk for the Health Board, which has been compounded as a result of specific service pressures in some of our high volume demand tumour sites; at Princess of Wales Hospital, Breast and Urology and Gynaecology in Swansea. • A HB trajectory has been planned for each Unit, based on updated activity and breaches from the previous 12 months. There has been more consistency in our performance since September , we have been reporting between 83% - 84% compliance against the 62 day target. The top three tumour sites across the HB for breaches remain as Breast, Gynaecological and Urology. Concerns remain with the Urology Pathway with a significant number of patients in backlog. Breast services remain out of balance mainly due to gaps in service provision and the ability to match up breast radiology with Breast Surgeon activity. Demand and Capacity remains the issue for Gynaecology. The Unit have been unsuccessful in appointing into the 4th Gynae-Oncology Consultant post.	• New Endoscopy live dashboard released on the 18th December 2018. • Upper GI pathway review and discussions to identify where bundling of diagnostic requests will be progressed following retire and return. • Gynaecology team working with Hywel Dda to look at options of utilising theatre capacity in Hywel Dda. • Detailed Radiology Demand and Capacity plan including reporting time requirements is being finalised. Informatics to include priority flags within data warehouse by the end of January in order to develop this further • Pathway review of out of area sarcoma patients • New surgical cancer tracker appointed in POW. To commence in post in January. • Breast radiologist post to be re-advertised. • New gynaecological clinic timetable to be implemented alongside one-stop PMB clinics to increase capacity. To be fully operational in January. • Gynaecological Rapid Access Clinic capacity to be increased following return of consultant from long term sick leave in December, which will help reduce waiting times	HB trajectory is 90% (WG target is 95%)	88%						Mel Simmons
		HCAIs															
	M25	**Achievement of C.Difficile trajectory (15 % reduction)**	Q1-4					At the end of Quarter 3, the cumulative number of C. difficile cases was 157, 27 cases less than the IMTP profile, and approximately 28% fewer cases compared with the same period in 2017/18.		NHS Wales Outcomes Measures	25% reduction (Q2 18/19= 112 compared with Q1 17/18= 150)	DoN	All DUs	Head of Nursing, IPC	Infection Control Committee	P&F Committee & Q&S Committee	Delyth Davies / Janice Price
	M26	**Achievement of S. Aureus bacteraemia trajectory (10% reduction)**						At the end of Quarter 3, the cumulative number of Staph. aureus bacteraemia was 141, 6 cases more than the IMTP profile, but 5% fewer cases compared with the same period in 2017/18.	• Delivery Units to progress PDSA style quality improvement activities, with a focus on invasive vascular devices, across acute sites. • Delivery Units to extend Aseptic Non-touch Technique training, with competence assessment, to medical staff.		9% increase (Q2 18/19= 101 compared with Q2 17/18= 94)	DoN	All DUs	Head of Nursing, IPC	Infection Control Committee	P&F Committee & Q&S Committee	Delyth Davies / Janice Price
	M27	**Achievement of E.coli bacteraemia trajectory (5% reduction)**						At the end of Quarter 3, the cumulative number of cases of E. coli bacteraemia was 304, 26 cases above the IMTP profile, but approx. 4% fewer cases than in the same period in 2017/18.	• Delivery Units to progress PDSA style quality improvement activities, with a focus on urinary catheters, across acute sites. • Delivery Units to extend Aseptic Non-touch Technique training, with competence assessment, to medical staff.		5% reduction (Q2 18/19= 272 compared with Q2 18/19= 287)	DoN	All DUs	Head of Nursing, IPC	Infection Control Committee	P&F Committee & Q&S Committee	Delyth Davies / Janice Price
	M28	**Rebalance mental health and learning disability models from inpatient to community-based models**	Q4					Progress report against innovation & transformation fund and psychological therapies fund accepted by WG. Second tranche of funding released to Health Board. Recruitment delays exist but being mitigated through bank and agency where possible. Strategic Framework for Adult MH endorsed by HB and Regional Partnership Board in November. Progress continues with reduction of people waiting for psychological therapies.	Agreed at November Board meeting that transformation programme resources necessary to support major change and programme structure and support to be agreed with COO.	Measure TBC		COO	MHLD DU	Head of Planning and Partnerships	MHLD Commissioning Board	P&F Committee	Gareth Bartley
	A24	Maximise use of 111 model	Q1-Q4					111 is fully utilised across ABMU Health Board.		Reduce healthcare, professional and Amber 2 ambulance conveyances to hospital from 2017/18 baseline		COO	PCS DU	Head of OOH	USC Service Improvement Board	P&F Committee	Kevin Duff
	A25	Improve access to GP care including changes to OOH services	Q1-Q4					Expansion of Remote working GPs to 37 (including GPs working on regional basis covering the Clinical Support Hub in 111). Move to HVS in Morriston to enable development of Roundhouse model agreed, target date for move middle of February 2019. 1 x Band 6 Nurse from 111 started to undertake sessions (7 hours per week) in Urgent Primary Care (UPC being used as descriptor of service instead of GPOOH to represent new multi-disciplinary make up of the service) as part of Foundation course for MSc. Establishing honorary contract for second Band 6 Nurse top start in Urgent Primary Care. Agreement reached with 111 to explore potential to rotate 111 Band 6 Nurses undertaking telephone triage to also undertake face to face appointments in Urgent Primary Care. Paramedics undertaking all evening and overnight home visits in Urgent Primary Care under a Service Level Agreement with WAST established 5th November 2018.		Meet NHS Wales outcomes standards for GP access Implement OOH changes Implement Primary Care Estates plans for 2018/19	95 % of GP practices open during daily core hours or within 1 hour of daily core hours, 88% of GP practices offering daily appointments between 17:00 and 18:30 hours	COO	PCS DU	Head of Primary Care	USC Service Improvement Board	P&F Committee	Lindsey Davies
	A26	Increase access to pharmacy-led care, maximising the use of the new Pharmacy contract	Q1-Q4					100% of community pharmacies across ABMU commissioned to deliver the Common Ailments Service by 31 December • 3276 consultations delivered to date. The prime objectives are to educate patients to seek the most appropriate/prudent Health Care advice and release GP time but with consultations estimated at £18 each (compared with £35 assumed for a GP consultation). the cost differential equates to an opportunity cost saving of over £6500 • 11% increase (98 total) in pharmacies commissioned to provide flu vaccination • New enhanced services commissioned to date have included: o Emergency Medications Supply Service (in 102 from 19 pharmacies) o 105 Pharmacies now open on a Saturday; 16 open evenings and Sundays o Medicines Management Support for Care Homes (June 2018)		Measures TBC		COO	PCS DU	Nurse Director PCS DU	USC Service Improvement Board	P&F Committee	Jason Crowl
	A27	Maximise impact of Community Resource Teams and community rapid response models on patient flow	Q2					This is part of the ABMU Winter Plan for 2018/19. ABMU has an integrated Frequent Flyers Service for Swansea City with acute, community, social care and third sector involvement who also link with Community Resource Teams. This supports the collaborative approach across units and agencies. The group identifies patients whose needs are increasingly accessing the Emergency department. For 2018/19 this arrangement is being developed further to identify a wider cohort of patients across the wider system.		Achieve Western Bay programme measures for admission avoidance Complete review of investment in intermediate care and CRTs to maximise return on investment		COO	PCS DU	Nurse Director PCS DU	USC Service Improvement Board	P&F Committee	Jason Crowl
	A28	Reinvest resources from anticipatory care planning into community nursing teams	Q2					Anticipatory care has been mainstreamed into core services		Reinvestment completed and technical efficiencies released (£0.5m)		COO	PCS DU	Nurse Director PCS DU	USC Service Improvement Board	P&F Committee	Jason Crowl
	A29	Review skill mix in community nursing and implement changes recommended by Cordis Bright and Capita	Q3-Q4					We are implementing a new policy to enable HCSW to administer medicine and are scoping the development of a band 4 HCSW role.		95% of recommendations implemented		COO	PCS DU	Nurse Director PCS DU	USC Service Improvement Board	P&F Committee	Jason Crowl
	A30	Development of EMI care home in-reach services to support care home staff in management of mental health needs of residents and avoid need for referral to ED or admission to acute or psychiatric inpatient care	Q1-Q4					Almost all posts recruited to but teams operational in each local authority area. Swansea in process of recruiting to 4 support worker posts at interview stage, all posts in NPT filled. Early indications in NPT area of reduction in length of stay on OPMHS acute ward with In reach team facilitating timely discharge. All teams support care homes through training, liaison and advice. Reviews of antipsychotic medication prescribing has seen a reduction in number s of individuals being routinely prescribed antipsychotics.		Reduction in admissions from EMI Care Homes on 2017/18 baseline		COO	MHLD DU	IMTP Lead MHLD DU	USC Service Improvement Board	P&F Committee	Gareth Bartley

Corporate Priority		Action	Timescale	Progress Q1	Progress Q2	Progress Q3	Progress Q4	Quarterly commentary on progress	Mitigating Action for Q4 if Amber or Red	Measure	Current position where numerical measures available	Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance	Lead
Unscheduled Care Service Improvement Plan Actions	A31	Implement joint Wales Ambulance Services NHS Trust (WAST) / Health Board initiatives outlined in Appendix 10	Q3					The joint work programme between WAST and the HB continues to be implemented – focussing on a reduction in HCP calls. • There has been a 10% reduction in HCP (green) patient conveyances to hospital in the 12 month period between January and December 2018, when compared with the same period in 2017. The total number of patients conveyed to hospital by ambulance also reduced by 3058 or 7% in 2018, compared with 2017.		Reduce conveyances to hospital for non-acute the 'Big 5' conditions against the 2017/18 baseline.	Green (HCP) calls have reduced by 20% when compared to Q3 of last year. Amber calls reduced by 0.3%.	COO		Asst COO	USC Service Improvement Board	P&F Committee	Jan Thomas
	A32	Implement revised falls pathway across the Health Board	Q1-Q4					Refresher training of care home staff on the i-Stumble version 1 tool across the 3 local authorities to improve the management of patients who have fallen but who have not incurred any physical injury. • I stumble version 2 had been approved and will be rolled out for trial implementation in the Pobl homes in NPT and in 4 local authority residential homes in Swansea. Training is planned to start with one home in NPT from November and will be rolled out to the remaining homes between December and January. Using this tool will support a reduction in risk of pressure damage for 'long lie' residents awaiting a lower acuity ambulance response. WAST has also commissioned 2 falls response vehicles in the HB as part of the winter plan to reduce un-necessary conveyance of falls patients to hospital by an emergency ambulance		Reduce conveyances for non-injured fall patients against 2017/18 baseline.		COO		Asst COO	USC Service Improvement Board	P&F Committee	Jan Thomas
	A33	Continue to develop ambulatory care models across the Health Board.	Q2					Implementation of models that support ambulatory care within existing resources continued in Quarter 3. Plans include: • Extending the medical day unit hours at Singleton from October between 8.00am and 8.00pm to divert appropriate patients from the front door. • Reviewing 3 ambulatory care pathways in Singleton – DVT,PE and pregnancy. • Introducing fast track referral pathway for post operative complication patients at Morriston. • Maximising the day unit at NPT hospital • Launching hot clinics in 3 new specialities in Morriston		25% of acute medical admissions to be managed through an AEC pathway - measures in development.		COO		Asst COO	USC Service Improvement Board	P&F Committee	Jan Thomas
	A34	Implement changes to surgical unscheduled care pathways at POW within resources, e.g. 'chole quick', ENT pathways, trauma and gynaecology pathways.	Q1					Ambulatory Emergency Surgery - delivery of a second test of change for six weeks from 4th June 2018 resulting in a 42% reduction in Emergency General Surgery admissions and improvement in 4hr performance ranging between 2.63% and 5.39% daily. • Surgical ambulatory emergency care unit was piloted in Q2 and able to demonstrate a positive improvement.	No further action can be taken as requires capital and revenue funding to progress. Scheme being considered by Cwm Taf Health Board for 2019-20 as part of IMTP process.	Contribution towards achievement of HB target for 4 - hour waits.		COO	POW DU	SD, POW DU	USC Service Improvement Board	P&F Committee	Gavin Owen
	A35	Psychiatric liaison service measures to be introduced.	Q1-Q4					Performance measures for response to referral introduced: • 1 hour response time for ED referrals • 4 hour urgent referrals • 72 hours ward referrals • Regular reporting on performance implemented. • Resources allocated to extend hours of services operation at weekends and posts recruited to. However maternity leave for existing staff members has had an impact on capacity as posts not backfilled. • Plans developed for extension of hours to midnight across 7 days however the Human Resources Department have advised that the Organisational Change Policy is followed to make these service changes. This process may potentially delay the plans to extend hours until the consultation period is completed and following return of existing staff from maternity leave.	Undertaking staff consultation for OCP regarding hours extension beyond existing 10pm.	98% compliance with 1 hour response time from referral to assessment for psychiatric liaison services. Reduction in numbers of frequent mental health attenders on 2017/18 baseline.	ED Response within 1 hour 76% and within 4 hours 91%	COO	MHLD DU	IMTP Lead MHLD DU	USC Service Improvement Board	P&F Committee	Gareth Bartley
	A36	Improve advance care planning for individuals who have advanced, progressive life limiting illness.	Q1					Macmillan-funded Advance Care Planning team in post		Optimise support for our patients and those important to them.		DoT		EoL Delivery Plan Lead	USC Service Improvement Board	P&F Committee	
	A37	Implement ECIP plan within resources at Morriston	Q2					The USC improvement programme for Morriston reflects the recommendations from ECIP.		Contribution to achievement of HB target for 4 hour waits on site.	67.67%	COO	MDU	SD, MDU	USC Service Improvement Board	P&F Committee	Alison Gallagher
	A38	Implement ECIP plan within resources at POWH.	Q1					The USC improvement programme for Princess of Wales hospital reflects the recommendations from ECIP The report from the NHS Elect plan has informed actions developed and implemented in Q1 and also going into future periods. Examples such as AESU (Q1) and frailty at the front door (Q2) came from this work. POWH ED implemented a "Minors in May" initiative which resulted in minors 4hr performance improving from 90.32% (225 breaches) to 97.55% (68 breaches) at the end of Q1. Minors stream vulnerability in evenings/overnight and during times of significant crowding within the ED.		Contribution to achievement of HB target for 4 hour waits on site.	76.10%	COO	POW DU	SD, POW DU	USC Service Improvement Board	P&F Committee	Gavin Owen
	A39	Ensure Minors streams meets 4 hour standard.	Q4					Minors performance has been affected by the majors demand in Q3. Minors stream vulnerability in evening/overnight and during significant crowding within the ED.	Additional ENP cover during late afternoons and evenings at POW ED funded through winter pressures funding to minimise minors breaches during this time.	100% of patients categorised as Minors to be managed within 4 hours.		COO	MDU / POW DU	SD POW / SD MDU	USC Service Improvement Board	P&F Committee	Alison Gallagher / Gavin Owen
	A40	Consistently implement SAFER flow bundle on all wards as a Quality Priority.	Q1					•The implementation and roll out of the SAFER flow principles remains a key element of our USC improvement plan and is overseen by the USC delivery board. • The findings from the DU complex discharge audit confirmed that there is evidence of wards where there is exemplar practice in the application of the SAFER process, however there remains variation in relation to wholesale implementation.	A discharge workshop held on 14th January reaffirmed that SAFER remains a priority for the organisation and a clinically led group will be implemented to drive consistent implementation. Delivery unit progress will be monitored at quarterly performance reviews. Measures that monitor improvements in patient flow include: • The number and percentage of stranded patients • The percentage of patients discharged before midday • The number and percentage of patients who have an estimated date of discharge to inform their discharge planning arrangements. A revised HB patient flow policy will be completed this quarter which will reinforce SAFER as the framework for ensuring patient flow and safety.	35% of patients discharged home before lunch. 100% of inpatients have an estimated Date of Discharge. Compliance with other metrics measured through the Patient Flow Work stream.		COO	All hospital units	Asst COO	USC Service Improvement Board	P&F Committee	Jan Thomas
	A41	Roll out TOCALS model to Singleton and POWH	Q1					Initial mapping underway. Project being taken forward between NPT Unit and PC&CS unit to map pathways regarding Discharge to Assess models		Model rolled out		COO	NPT DU	NPT SD	USC Service Improvement Board	P&F Committee	Susan Jones
	A42	Implement measures for mental health services to general wards	Q1					The liaison service continues to prioritise referrals for AMAU to support older adult patients with cognitive impairment to prevent admission to acute general wards and aim for patient to return to their own home. • Liaison support workers work with identified patients and support them during their admission.		Improvement in compliance with same day assessment by psychiatric liaison team on 2017/18 baseline. Reduction in numbers of patients on general wards awaiting a MH bed.	Number of referrals identified as urgent has increased per month from the beginning of 2018-19. Urgent ward referrals seen within 24 hours -97%. Routine referrals seen within 48 hours - 85%	COO	MHLD DU	MHLD SD	USC Service Improvement Board	P&F Committee	Gareth Bartley
	A43	Implement comprehensive geriatric assessment for all patients >75 years (Quality Priority)	Q1					The original plans to enhance and develop frailty models during the year within existing resources have been largely been implemented. This includes the following services: o TOCALs into Neath Port Talbot Hospital o The full implementation of the multi disciplinary older persons service at Singleton hospital (ICOP) o Embedding the redesigned frailty model at POW. This includes enhancing senior clinician presence at the front door of the hospital from November. o Implementation of the older persons assessment service at the front door of Morriston hospital. • The intermediate care consultants all proactively undertake CGA's.		95% of patients over 75 years to have a CGA - measure sin development.		COO	All hospital units	Asst COO	USC Service Improvement Board	P&F Committee	Jan Thomas
	A44	Implement measures for the new Western Bay discharge standards.	Q2-4					Discharge standards now in place. New audit tool to assess against the standards is being evaluated.		Compliance with the measures		COO	All hospital units	Nurse Director PCS DU	USC Service Improvement Board	P&F Committee	Jason Crowl
	A45	Trial innovative ways to address deficits in domiciliary care and care home delays.	Q2					Additional support is being provided to enable improve discharge at an earlier stage to reduce the demand on domiciliary care. Working with SCS re contracting a revised model of domiciliary services. Working with NPT around supporting rapid access domiciliary services.		Sustained reduction in Medically Fit for Discharge patients > 7 days on 2017/18 baseline		COO	All hospital units	Nurse Director PCS DU	USC Service Improvement Board	P&F Committee	Jason Crowl
	A46	Develop Health Board - wide deconditioning strategy - linked to SAFER flow bundle as a Quality Priority.	Q3					•The implementation and roll out of the SAFER flow principles remains a key element of our USC improvement plan and is overseen by the USC delivery board. • The findings from the DU complex discharge audit confirmed that there is evidence of wards where there is exemplar practice in the application of the SAFER process, however there remains variation in relation to wholesale implementation.	A discharge workshop held on 14th January reaffirmed that SAFER remains a priority for the organisation and a clinically led group will be implemented to drive consistent implementation. Delivery unit progress will be monitored at quarterly performance reviews. Measures that monitor improvements in patient flow include: • The number and percentage of stranded patients • The percentage of patients discharged before midday • The number and percentage of patients who have an estimated date of discharge to inform their discharge planning arrangements. A revised HB patient flow policy will be completed this quarter which will reinforce SAFER as the framework for ensuring patient flow and safety.	Strategy Developed		DoT	All hospital units	Asst DoT	USC Service Improvement Board	P&F Committee	Alison Clarke
	A47	Develop early supported discharge rehabilitation model	Q2					ESD for COPD supported by IBG and being rolled out. ESD for stroke being developed as a joint proposal between Morriston and Singleton units. Discharge to Assess model also in development. ESD for Older People pilot started in NPT in late September - results to be evaluated in December.		Model developed		COO/DoS	All hospital units	Asst DoT	USC Service Improvement Board	P&F Committee	
	A48	Implement Service Remodelling programme in acute hospitals	Q2					• Frailty at the Front Door models developed on all three main hospital sites • ESD for COPD being rolled out across the Health Board • Innovative enabling ward in place at NPTH • Continuing focus on SAFER flow bundle • Improvements in rehab pathways and pull through to community hospitals • Public engagement undertaken on Tranche 1 and Board decision made to proceed with additional bed closure on a phased basis • 106 adult non-mental health beds (acute and community hospitals) beds closed over the last 18 months • Monthly evaluation of system impacts through Service Remodelling Work stream Group • Joint Evaluation Group with partners established - first meeting 30th November • Bed Utilisation Survey undertaken on 3rd October - results will be presented to Executive Team on 28th November.	●Improvement actions continue through the USC Improvement Board ● Phased completion of NPTH and Singleton schemes as agreed by Board ● Roll out of ESD for COPD	Service remodelling schemes implemented in line with financial plan.		COO/DoS		Head of IMTP Dev	USC Service Improvement Board	P&F Committee	Nicola Johnson
	A49	Implement new service models for Community Hospitals	Q2					Strengthened reablement focus, supported by PJ Paralysis. Service pathways at Gorseinon have been linked with Morriston Acute Hospital with Consultant supporting care in emergency department enabling the community hospital to provide step up services. Further work being undertaken through the Clinical services Plan on future role and rehabilitation models.		Community Hospital models implemented in line with financial plan.		COO/DoHR	PCS DU	Nurse Director PCS DU	USC Service Improvement Board	P&F Committee	Jason Crowl
Stroke Service Improvement Plan Actions	A50	Confirm thrombectomy pathway for ABMUHB residents	Q1					• This will be a commissioned service by WHSCC from the 1st April 2019 – currently local arrangements are in place and dealt with on a patient by patient basis.	WHSCC commissioned Service planned to be in place from the 1st April 2019.	Pathway in place.		COO		Assoc Director R&S	USC Service Improvement Board	P&F Committee	Malcolm Thomas
	A51	Promote FAST in the identification of strokes	Q1-Q4					Continuing to support National work / communications.		N/A		COO		Assoc Director R&S	USC Service Improvement Board	P&F Committee	Malcolm Thomas
	A52	Continue to develop TIA services	Q1-Q4					5 day services are operational at both Morriston and POW units – NPT does not currently have a 5 day service and the clinical and managerial leads of both Morriston / POW and NPT have been tasked with finding an appropriate resolution.	Service Director discussions to be completed on where best to provide the NPT service.	Access to TIA clinic within a number of days from referral (TBC)		COO		Assoc Director R&S	USC Service Improvement Board	P&F Committee	Malcolm Thomas
	A53	Capture patient reported outcomes through occupational therapy patient survey.	Q1-Q4					No information available	No information available	Increase in use of PROMS		DoN		Assoc Director R&S	USC Service Improvement Board	P&F Committee	Janet Ivey
	A54	Improve access to 'life after stroke' clinics.	Q3					No information available		Reduction in the number of bed days associated with patients on the stroke rehabilitation pathway against 2017/18 baseline.		COO		Assoc Director R&S	USC Service Improvement Board	P&F Committee	
	A55	Refresh the business cases for ESD services and to assess opportunities to reinvest existing resources to improve services.	Q3					ESD for COPD supported by IBG and being rolled out. ESD for stroke being developed as a joint proposal between Morriston and Singleton units. Discharge to Assess model also in development. ESD for Older People pilot started in NPT in late September - results to be evaluated in December.	ESD Business Cases being integrated within Delivery Unit IMTPs.	Increase the number of patients receiving early supported discharge through a community rehabilitation model, on 2017/18 baseline.		COO		Assoc Director R&S	USC Service Improvement Board	P&F Committee	Malcolm Thomas
	A56	Ensure all stroke palliative patients are managed in accordance with the All Wales Care Decision Tool for care in the last days of life.	Q1-Q4					All Wales Care Decision Tool available across the Health Board		Increase in number of patients who are managed in accordance with the All Wales Care Decision Tool against 2017/18 baseline.		DoT		EoL Delivery Plan Lead	USC Service Improvement Board	P&F Committee	
Planned Care Service Improvement Plan Actions	A57	Roll out and develop use of E-Referrals.	Q1-Q4					98% of e-referrals in Q3 were prioritised electronically. Two specialities remain outstanding in implementing WPRS (Burns and plastics and cardiology West). Cardiology West is on schedule to go live in Q4.		All referrals submitted through e-referral route.	98% of e-referrals are prioritised electronically	COO/DoT		Asst Dir of Informatics	Planned Care Service Improvement Board	P&F Committee	Matt John
	A58	Build whole system pathways	Q1-Q4					Frailty, diabetes and COPD pathways being developed in accordance with the Annual Plan and Commissioning Intentions for the IMTP for 2019-22		Identify key pathways with Primary Care to develop improved management of the patient activity - enabling the patient to be treated and managed appropriately.		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee	Chris Morrell
	A59	Planned care programme delivery of changed pathways of care	Q1-4					Audiology, eye care and dental planned care pathways being developed in accordance with the Annual Plan and Commissioning Intentions for the IMTP 2019-22		Audiology initiative to be in place reducing referrals into secondary care. Build Optometry likes for Supporting Glaucoma activity.		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee	Chris Morrell
	A60	Extend the Planned Care Programme to additionally cover OMFS, Gynaecology and Vascular Surgery as part of the roll out programme.	Q1-4					National programmes delayed.	National Programmes delayed	Initialise new Planned Care programme groups within the Health Board - working with the National programme roll out. Set up appropriate data sets to create base line and develop models of care consistent with national evidence. Develop a resilient and sustainable plan.		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee	Malcolm Thomas
	A61	Develop experience gained from current virtual clinics and share across other specialities.	Q1-4					POW Business Case being developed. Patient Knows Best technology being rolled out to embed self-management.	NWIS PROMs now working within Orthopaedics and PKB being piloted in Urology. Shared experiences of new ways of working being discussed in Outpatient Modernisation group.	Virtual clinics already developed in planned care programme activities - share knowledge and develop approaches for increased use in other specialities across the Health Board where appropriate.		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee	Malcolm Thomas
	A62	Develop non-medical solutions for patient review - extended workforce skills for Nursing and other professionals	Q1-4					Work has been undertaken in Optometry, Audiology, and in a number of nurse led services across a range of specialties.	Extended models being rolled out - i.e. extended ODTC plans into Primary care	Continue with Audiology / Optometry / Therapies / Dentistry and extended Nurse Practitioners across range of services.		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee	Malcolm Thomas
	A63	Review New to Follow-up ratios	Q1-4					• New – 8,575 DNAs (6.3%) against trajectory of 8,129. • FUP – 18,537 DNAs (7.7%) against trajectory of 18,860. • In 2017/18 there were a total of 60,912 (18,406 New, 42,506 Follow Up). • The Health Board Annual Plan 2018/19 has identified a target of 10% reduction in New Outpatient DNAs for 2018/19. The Outpatient Improvement Group has also applied this target to Follow Up DNAs. • New DNA rate performance is being maintained at 6.3%; Follow Up DNA performance is being maintained at 7.7%.		Ratios meeting national best practice	See O32	COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee	Malcolm Thomas
	A64	Develop clinical office sessions in job plans for key clinicians.	Q1-4					Delivery Units to implement as part of the Virtual clinic developments and impact.	Job Planning is with the Delivery Units to address.	Greater throughput and active monitoring rather than face to face contacts		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee	Malcolm Thomas
	A65	Develop Theatre Efficiency Board role in improving performance across sites.	Q1-4					Theatre Efficiency Board set up with Terms of Reference and Multi Disciplinary forum. • Local Delivery Units also have theatre committees to take forward local actions. • Information and performance measures are being reviewed.	Theatre Board arrangements under review and with a greater focus on Performance improvement.	Challenging Performance and building best evidence base line performance measures.		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee	Malcolm Thomas
	A66	Develop and implement best practice agreed solutions to improving pre assessment arrangements.	Q3					Pre Assessment Task and Finish Group set up and has made recommendations which are now being taken forward in discussion with the Morriston Delivery Unit. Clinical guidelines have also been identified and are being consulted on.	Pre Assessment changes are under consultation during January - changes are anticipated to be introduced during March 19.	Develop and agree best practice Finalise and introduce revised Sop's Agree and implement proposed changes Reduce on the day cancellations / eliminate not fit for surgery patients and those that no longer require treatment - increased slots available.		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee	Malcolm Thomas
	A67	Review theatre scheduling of activity.	Q1-4					Local Theatre groups are reviewing utilisation and access – fallow theatre sessions are being moved to areas requiring greater access	Work is on going and changes to monitoring being planned as part of the performance focus changes mentioned above.	Look to introduce IT to improve selection / planning and communication between departments and theatre lists.		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee	Malcolm Thomas

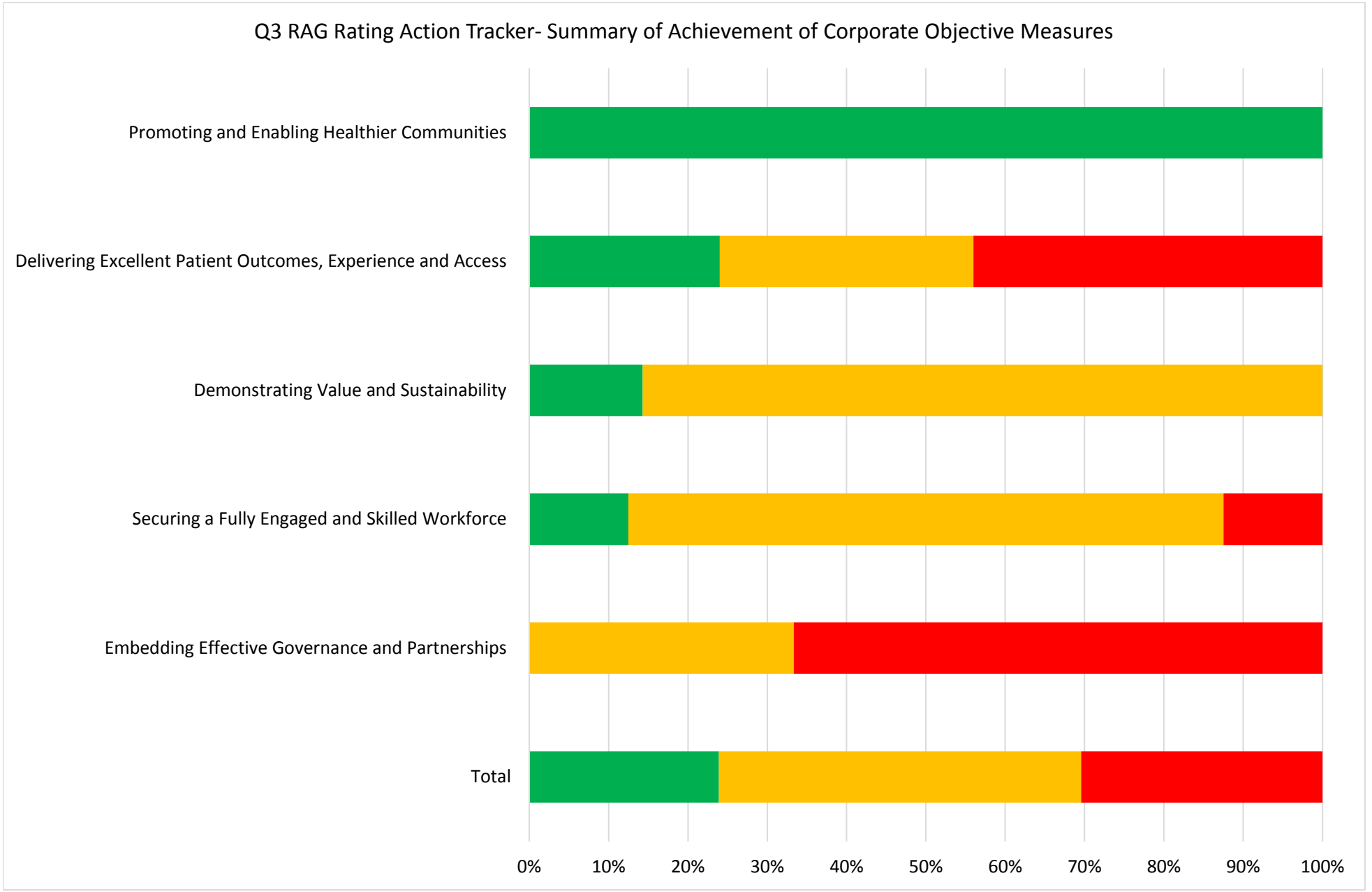
Corporate Priority		Action	Timescale	Progress Q1	Progress Q2	Progress Q3	Progress Q4	Quarterly commentary on progress	Mitigating Action for Q4 if Amber or Red	Impact Measurement: Measure	Impact Measurement: Current position where numerical measures available	Responsibility and Accountability: Exec Lead	Responsibility and Accountability: Delivery lead - mechanism	Responsibility and Accountability: Monitoring lead	Responsibility and Accountability: Reporting and monitoring	Responsibility and Accountability: Board Governance	Lead
	A68	Review areas where new equipment / technology could shift activity to Day Case or Outpatient procedure / other hospitals within ABMUHB not compromised for beds.	Q1-4					Solutions are being progressed in areas such as plastic surgery and orthopaedic hands to move day case activity out of theatres and into outpatient treatment sessions where it is clinically appropriate and evidence based. Approval has been given to develop a dedicated Plastic Surgery Day case Unit in Morriston Hospital. Building will be completed by the end of March 2019 with benefits being seen in 2019/20.		Review current activity performed in Morriston that could be completed safely in Singleton. Review procedures that would be best performed as day case.		COO/DoT		Asst DoS	Planned Care Service Improvement Board	P&F Committee	Darren Griffiths
	A69	Work with partner Health Boards to identify regional solutions to deliver routine elective surgery in protected capacity.	Q1-4					Discussions have taken place and a solution to locate a regional static staffed theatre unit at either the Morriston or Prince Phillip site to protect elective orthopaedic capacity has been investigated. However recent changes to the plans within Hywel Dda have put these discussions on hold for 2018/19.		Fewer cancelled procedures. Timely access and reduced RTT waiting times pressures.	36% increase in number of elective procedures cancelled due to lack of beds (Sep-18 compared with Sep-17). 21% less patients waiting over 36 weeks for treatment (Sep-18 compared with Sep-17).	COO/DoT		Asst DoS	Planned Care Service Improvement Board	P&F Committee	Darren Griffiths
	A70	Clear full year capacity plans in place to deliver agreed year end position.	Q1					RTT capacity plans are in place which delivers the health board year end profile of 2,664 for patients waiting over 36 weeks and Nil for patients waiting over 26 weeks for a first outpatient appointment. Delivery against the plans are monitored and challenged on a weekly basis to hold services to account for their plans. Where plans become off profile, further solutions are identified to recover the position.		Signed off plans in place. Resources agreed. Accountability letters issued.		COO COO/DoF COO-DoF		Asst DoS	Planned Care Service Improvement Board	P&F Committee	Darren Griffiths
	A71	Implement inpatient patient surveys in cardiac services and ophthalmology.	Q2					Filtered from the Pivot 14.1.19: Date range: October, November and December 2018 Inpatients: Dan Danino, eye theatre, cardiac ITU, Cardiac short stay unit, CHDU, Cyril Evans, coronary care unit, Ward 4, Ward c, Ward 9, Friends and Family returns = 692 All Wales Surveys = 130 Outpatients: eye unit, Orthoptics, corridor 7, RACE, Cardiac outpatients, Cardiac rehab, cardio respiratory, Cardiology Day Unity, Cardiology Department, Clinical physiology, Friends and Family = 251 All Wales Surveys = 2	Continue to collate feedback from all areas & monitor data. Automatic online real time alerts are generated and sent to ward managers & PALS teams to ensure immediate action is taken and situations or concerns resolved. Weekly results are sent to all areas & action plans generated locally by delivery unit.	Surveys in place		DoN		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee	
	A72	Ensure that roll of F/U Priority Actions from planned care are sustainable.	Q1-4					• Sustainability plans have been agreed in Ophthalmology. • Urology is implementing PKB – self managed care – the service already has 1200+ virtual patients. • ENT discharging is meeting agreed guidelines – clinical exception is currently being reviewed. • Orthopaedic PROMs for hips and knees is in the process of being implemented once the NWIS software is released.	Implementation of Planned care changes are underway. PKB roll out to be completed by April, Orthopaedic PROM (post Surgical in place) pre assessment stage - January onwards. ENT guidelines being monitored with clinical re evaluation being undertaken at a National Level for one sub specialty area.	Reduced backlog in FunB / appropriate and timely monitoring of patients.	3% increase in delayed follow-ups (Dec-18 compared with Dec-17).	COO / DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee	Malcolm Thomas
	A73	Roll out experience and best practice across other specialities to reduce FuNB pressures.	Q1-4					PKB roll out to other specialties already underway – and looking to agree into other areas such as Rheumatology.	Practices being shared within Outpatient Modernisation Board. Delivery units to implement.	Agree with clinical teams programme of work - initially reviewing - OMFS / Vascular surgery and Gynaecology.		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee	Malcolm Thomas
	A74	Identify appropriate IT solutions such as Amplitude / other PROM's based systems to assist monitoring and planning of reviews.	Q1-4					NWIS PROMs roll out being developed - concern around manual work around.	NWIS PROMs implemented in two of the five phases. NWIS to continue to develop system.	Continue roll out of PROM's systems. Support NWIS developments and identify alternative options such as in Ophthalmology.		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee	Malcolm Thomas
	A75	Review Discharging arrangements to safely discharge patients / and facilitate See on symptom arrangements.	Q1-4					No information available		Discharge arrangements reviewed and plan implemented. See on Symptom arrangements in place. Ensure Primary Care services involved and aware. Ensure Primary Care services involved and aware.		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee	
	A76	To support symptom awareness campaigns, collaborate with Primary Care to make available risk assessment tools, training materials and provide access to specialist support.	Q2					ABMU HB's Macmillan GP Facilitator has been doing work to improve earlier diagnosis. This has been mainly educational for GPs and includes lectures at the Protected Time for Learning for the clusters as well as lunch-time clinical sessions. We have been highlighting the latest evidence with regard to thrombocytosis as a possible cancer marker and making GPs aware of the ABMU CXR direct to CT pathway. Improved patient awareness of the pathway has been through use of the leaflet 'Had a test- need another' when GPs give the CXR request form to patients. Collaborative working with the radiology Department has meant that the same information is now given when patients arrive at x-ray reception through laminated information sheets and posters.		Reduced number of patients diagnosed in an emergency setting. Improved screening uptake. Reducing the proportion of patients referred who will actually be found not to have cancer.		COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A77	Using CAPITA report and benchmarking information implement demand/capacity plans for endoscopy and gastroenterology.	Q2					The Cancer Information and Improvement team has built on the work undertaken by CAPITA last year and undertaken a full capacity review of the following parts of the pathway: • A full demand and capacity profiling exercise of USC, Urgent and Routine work has been undertaken for the Endoscopy service delivered via the NPTH, Singleton and Morriston units looking at delivery of bronchoscopies, gastroscopies, colonoscopies, flexible sigmoidoscopies or any dual combination of the previously mentioned procedures within those units. • A prototype live queue dashboard has been developed and verified. We are in the process of working with Informatics colleagues to activate the live version in due course. The Cancer Information and Improvement team have continued to work towards their goal of providing the service with a visual interface of the queue's at the different component stages of the current cancer pathways. It is the belief of the team that Service Groups should have accurate and up-to-date information in relation to demand and activity, that they are able to monitor and react to in real time, so they can actively manage their systems before the breaches occur. A full capacity review has been undertaken of the following parts of the pathway: Demand & Capacity Modelling First OPA: Phase one was to create a suite of 'live dashboards' by which we can monitor our weekly Urgent Suspected Cancer (USC): • Referrals (demand) • Activity (number of USC patients seen at their first clinic appointment) • Variance [the cumulative difference between our USC demand				COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A78	Profiling endoscopy, imaging and pathology demand to ensure sufficient capacity is in place to support compliance with cancer waiting times and the introduction of the single cancer pathway.`	Q2-4					As above for endoscopy and pathology • The Health board is in the process of moving to one radiology system across all of its sites. The East of the HB (Princess of Wales and Neath Port Talbot hospitals) has been using this system for some time. The west of the HB will be moving to the new Radis system on the 24th of November. • In preparation for this the Cancer Information and Improvement team has developed a prototype live dashboard view that will allow the user to access current queue information for all CT,MR and USS scans for all USC, Urgent and Routine scan requests received in the Health Board. • The prototype dashboard and accompanying stock and flow models have already been built and are currently entering the verification phase of testing ahead of a live click view dashboard being made available. The dashboard will allow users to actively manage queue length and the outputs from the dashboard will be used to power models of the system which will allow us to ensure we have enough capacity available to complete the diagnostic phase of the new single cancer pathway. As above. The HB have submitted demand and capacity information				COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A79	Expansion of Rapid Diagnostic Centre (RDC) service - increase clinics and GP clusters to 4.	Q2					ABMU HB successfully secured funding via the Wales Cancer Network to develop and deliver a 2 year pilot based on the Rapid Diagnostic Clinic concept. Funding was made available from April 2017 and the first patients were seen in June 2017. Based on the 12 month outcome data, the initial results from the RDC pilot is very encouraging . The data reports 83 clinics held and 228 patients seen (128 female and 112 male) with the average age being 69.4 years old. Preliminary results also suggest that the RDC model supports the single cancer pathway 28 day diagnostic metric, delivering a (non-histological) diagnosis on average within 4.4 days based on indicative ABMU data. Despite the roll out of a novel clinic model, the outcome data with a 10.5% conversion rate for the clinic is extremely positive with evidence of a good patient and referrer experience. Despite the increasing referrals, as a result of excellent engagement and communication between primary and secondary care the conversion rate suggests that the system must trust the GP instinct and the service has not been flooded to date. ABMU have agreed that they will continue to support the Rapid Diagnostic Clinic (RDC) at Neath Port Talbot Hospital. The Welsh Cancer Network have provided additional funding to enable the RDC to complete a 2 year local operational evaluation and also provide clinical data to facilitate a national evaluation of the pilot.		Reduced number of patients diagnosed in an emergency setting. Improved screening uptake. Reducing the proportion of patients referred who will actually be found not to have cancer. USC patients having 1st OPA within 14 calendar days and diagnostics being undertaken within 10 days.		COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A80	Increase sustainable outpatient capacity for USC patients.	Q1					A 'live dashboard' by which we can monitor our weekly Urgent Suspected Cancer (USC) Breast, Colorectal, Urology, Gastroenterology and PMB referrals (demand), activity (number of Urgent Suspected Cancer patients seen at their 1st clinic appointment), waiting list (the cumulative difference between our USC demand and activity i.e. work-in-progress) and Lead- times (time from referral to first seen in clinic) has been produced. • The new Vitals chart section allows us to predict future lead times (referral received to patient first seen) and monitor them against the target maximum lead-time of two-weeks. This system is designed to provide a real time feedback loop that will allow the service managers to monitor the USC queues and tailor the 'sprint' capacity i.e. short term 'waiting list activity' to bring the WIP down before patients' lead-times exceeded two weeks.	• New first outpatient OMFS pathway stage agreed and taken forward with Primary Care with a plan to commence in April. • New neck lump pathway agreed with a plan to implement at the end of January. • Cancer Improvement Team have developed Demand & Capacity analysis for first outpatient appointment across most specialties managing suspected cancer referrals; these will be developed into live dashboard views by Informatics with timeframes for this development to be determined				COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A81	Implement centralised breast outpatient/diagnostic centre for NPTH and POWH patients and align breast pathways across the Health Board	Q1					• Breast services remain out of balance mainly due to gaps in service provision and the ability to match up breast radiology with Breast Surgeon activity. • All USC patients will attend a One-Stop Triple Assessment clinic and will have mammography if >40 years and clinical examination performed by the surgeon • A Breast Business meeting was held on September 4th 2018 to standardise pathways. An action plan is being developed to address the inconsistencies identified in the pathway. • Live demand and capacity modelling has been provided to the Unit via the Cancer Dashboard and demonstrated the USC capacity required to meet demand and maintain timely activity throughout the year on both Singleton and Neath Port Talbot sites. This can be used to prospectively predict the lead time for patients in the queue. • Breast Cancer Peer Review undertaken on 25th June 2018. • Issues continue with delivery of Breast services to deliver timely triple assessment	Breast services remain out of balance mainly due to gaps in service provision and the ability to match up breast radiology with Breast Surgeon activity and long term sickness of a Breast Consultant. • A one stop breast clinic runs from the Neath Port Talbot site , with current waits of around 3 weeks to be seen. • Working with radiology colleagues to ensure clinics are covered/backfilled and extras in place wherever possible • Breast radiologist post to be re-advertised.				COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A82	Review the performance and the pathways in POW Urology services, in line with All Wales peers.	Q2					•• Demand and Capacity modelling work has been undertaken for Urology Outpatients and available to use via the Cancer Dashboard • Further work completed to allow single-handed template clinician to do more dedicated DSU weekly list. • Clinical gaps being worked through using locum agencies as much as possible.				COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A83	Revise Post-Menopausal Bleeding pathway.	Q2					The Singleton Delivery Unit is working towards moving from a 3 days a week to a 5 day a week PMB service, however this requires the support of POW consultants where consultant staffing is an issue.• PMB One-stop clinic commenced 5th November. Current waiting list for PMB is short and capacity converted to outpatient hysteroscopy to reduce waits for patients following the previous clinic model.• Additional clinics arranged on ad hoc basis to help reduce USC waiting times. New clinic timetable implemented alongside one-stop PMB clinics from Nov18 to increase capacity. • Revised process for Swansea vulval USC referrals. Increased capacity in RAC.				COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A84	Deliver revised Post-Menopausal Bleeding pathway.	Q2					The Singleton Delivery Unit is working towards moving from a 3 days a week to a 5 day a week PMB service, however this requires the support of POW consultants where consultant staffing is an issue. As above				COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A85	MyoSure activity to be introduced to Singleton and Neath	Q3					One-stop diagnostic model for postmenopausal bleeding and pelvic masses implemented				COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A86	Cancer improvement Board to focus on immediate performance issues as well as sustainable improvement breast, gynaecology and urology.	Q1					Cancer Improvement Board established and Terms of Reference agreed. Performance is a continuous agenda item. Meetings are held on a monthly basis.				COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A87	Support and Challenge Panels to evolve to ensure constructive challenge; update and support to each MDT.	Q1					Support and Challenge panels continue to be scheduled and held between the MDT Leads and the Health Board Cancer Lead Clinician and Cancer Quality & Standards Manager.				COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A88	Action plans to improve Cancer Performance to be delivered by each Unit at tumour site level in 30, 60, 90 day view.	Q1					Delivery Unit Recovery Plans are in place and continue to be monitored and reviewed at the monthly Cancer Improvement Board.				COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A89	Recommendations following the MDT review to be implemented and audited.	Q2					Recommendations from MDT assessments are discussed with the MDT Lead and relevant management teams at the Support & Challenge Panels. • Peer review provides assurance to the Health Board regarding the quality of care being provided and recommendations for the MDT cancer teams as to aspects of the service that are of particularly high quality worthy of sharing with others and those aspects of care that could be improved. In cases of serious concerns or immediate risks in terms of service quality and/or patient safety specific notifications are made to Health Boards and to Healthcare Inspectorate Wales.				COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A90	Implementation of revised MDT Operational policy and MDT Co-ordinator job description.`	Q1					Revised MDT Operational Policy implemented in January 2018. Revised MDT Co-ordinator job description implemented at POW. Implementation at Singleton remains incomplete. New MDT Co-ordinator job description implemented across HB				COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A91	Provide regional models of cancer delivery, innovation, integrated pathways, create economies of scale and provide more specialist treatment closer to home.	Q4					A Regional Collaboration for Health (ARCH) is a partnership between ABM University Health Board, Hywel Dda University Health Board and Swansea University. This looks at the entity of the cancer pathway, in partnership with Public Health and Primary Care. The ARCH partners are working to improve the health, wealth and wellbeing of South West Wales by delivering better health, skills and economic outcomes for the people of this region. The Non – Surgical Cancer Strategy for South West Wales is one of the first projects to be developed through the ARCH partnership. The strategy focuses on delivering excellent care, improved outcomes and supporting those living with and beyond cancer. The strategy is aligned to The Cancer Delivery Plan for Wales (2016 – 2020) and its vision is "to provide the best possible care for the people of South West Wales" To help to deliver the aims and vision of the strategy, the following objectives have been agreed:- • Develop sustainable regional workforce • Develop local services linked to the specialist cancer centre • Embed a regional culture of research and innovation • Maximise digital solutions.	ARCH Strategy has been included in the Corporate Cancer IMTP to ensure focus is maintained.			COO/DoS		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
Cancer Service Improvement Plan Actions	A92	Clear plans to deliver compliance with the single suspected cancer pathway by April 2019.	Q4					No formal announcement has been made by the Cabinet Secretary yet, however the Wales Cancer Network and colleagues from Welsh Government are meeting on the 25th October 2018 and an announcement expected in November confirming a move from shadow reporting to dual reporting of both the SCP and current USC and NUSC targets in 2019. The HB has been shadow reporting the Single Cancer Pathway since January 2018. It is important to note that because the SCP only applies to patients whose suspicion date is identified as the 1st of January 2018 or later, performance for the months of January and February are by default 100% compliant, as 62 days has not elapsed during that time.	In November 2018, the Cabinet Secretary formally announced the introduction of the SCP, with Wales publically reporting from June 2019. £3 million investment has been allocated from April 2019 as part of the NHS budget settlement to support the introduction of the new pathway and to support performance and quality improvements in the pathways of care. It is expected that there will be local focus on diagnostic capacity, efficiency and investment to improve performance. One of the key priority areas to improve outcomes, reduce variation and support the implementation of the SCP is the development of common pathways across the NHS for specific cancer disease groups. 8 optimal pathways for a number of high volume tumour groups have been developed by the All Wales CSG's and circulated to our Cancer Multi-disciplinary Teams. Work has commenced with Lung and Colorectal to map and compare pathways against the optimal				COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A93	Governance arrangements for regional/specialist MDT's to be agreed and MUO's to be implemented.	Q2					The WCN have appointed a Project Manager who will lead on this initiative nationally with the aim to drive forward this work and enable a collaborate approach across all the relevant areas. HB Cancer Executive Lead, Cancer Lead Clinician and Cancer Quality & Standards Manager met with the Project Manager on 8th June 2018 and are awaiting further correspondence.	Awaiting correspondence from WCN	As line 93		COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons

Corporate Priority		Action	Timescale	Progress Q1	Progress Q2	Progress Q3	Progress Q4	Quarterly commentary on progress	Mitigating Action for Q4 if Amber or Red	Impact Measurement: Measure	Impact Measurement: Current position where numerical measures available	Exec Lead	Responsibility and Accountability: Delivery lead - mechanism	Responsibility and Accountability: Monitoring lead	Responsibility and Accountability: Reporting and monitoring	Responsibility and Accountability: Board Governance	Lead
	A94	Implement Non-Surgical Cancer Strategy	Q1-4					In progress (see A91)				DoS/COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Les Hammond
	A95	Continue participation in the cancer peer review programme 2018/19 - Gynaecology; Thyroid; Breast; Sarcoma; skin; Acute Oncology and Teenage, young adults and infants.	Q1-4					The Health Board has fully engaged with the peer review process since its implementation. We have recently participated in the second cycle review for Breast Services and the first cycle for Thyroid, and for Acute Oncology Services, which is considered to be an important aspect of quality cancer services, both in terms of prevention and early diagnosis together with surveillance, rehabilitation and survivorship initiatives. Each site-specific service has developed an action plan to address the concerns raised in the outcome reports. These are monitored by the Cancer Improvement Board. Peer Review has been a positive experience. It has provided an opportunity for clinical and management teams to address adverse findings with a prudent approach, reviewing services together to resolve quality and safety issues where identified and work to maintain, improve and transform services as needed. Ongoing.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A96	On recommendations of ICHOM take value based healthcare approaches forward in Lung	Q1-4					Baseline PROM data collection initiated in Morriston Lung Clinic. No progress with follow up collection. No progress with extending to Singleton or NPT yet.	Discussion with National Clinical Lead re support to consider expansion options. Links made with HDHB re sharing of learning.			DoS/MD		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Kerry Broadhead
	A97	Deliver on peer review action plans, within resources.	Q1-4					• Action plans reviewed and monitored via the Cancer Improvement Board. • Outstanding actions reviewed at the October Cancer Improvement Board. • Common themes to be addressed include the Acute Oncology Service provision at Princess of Wales Delivery Unit, single handed surgeons, oncology provision, holistic need assessments and governance arrangements for the regional MDT's. **Ongoing**				COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A98	Increased focus on Gynaecology theatre booking and utilisation.	Q1					Ad hoc sessions only possible at Singleton Delivery Unit when there are suitable patients – currently being delivered due to goodwill of surgeon	Additional theatres arranged on ad hoc basis to increase surgical capacity			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A99	Review of order of lung diagnostics and need to return to MDT for discussion post-test (esp. CPEX and CT Guided biopsy).	Q2					A Macmillan Quality Improvement Manager was appointed at the beginning of September and has begun to review the lung cancer pathway in ABMU HB and will be establishing a joint collaborative with Hywel Dda for tertiary lung services following appointment of a Macmillan QI Manager at Hywel Dda. **Ongoing**	Work currently being undertaken in Lung includes:- - Review of the time from referral received\receipted to first outpatient appointment for USC patients. Checking when the referral is receipted in to hospital as there appears to be a hidden wait for referrals receipted on the system.					Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A100	Review of pathways and implementation of improvements.	Q1-4					8 optimal pathways for a number of high volume tumour groups have been developed by the All Wales CSG's and circulated to MDTs. Work has commenced with Lung and Colorectal to map and compare pathways against the optimal pathways to understand variance and consider improvements required at the various steps. **Ongoing**	**As above**			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A101	To further develop Acute Oncology service and plan for the sustainability of the service.	Q2					The AOS service in the Princess of Wales is currently being constituted. The Clinical Nurse Specialist has been appointed and is due to start in Quarter 2 of 2018-19. The coordinator has been appointed and started in May 2018 and is preparing the unit for data collection and networking prior to the start of the service. The clinical lead post has been advertised 5 times with no applicants for the 2 sessions. Discussions with Macmillan in mid May 2018 have provided a further option of an appointed clinical lead from a neighbouring unit and this is being explored.	Initial AOS Steering Group scheduled for 25th January 2019 to discuss future developments.			COO/DoS		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A102	Develop a framework for support, development and ultimately transformation of not only Macmillan CNS posts, but for all cancer nursing posts, improving delivery on key worker, holistic needs, written care plans and patient experience.	Q4					The Macmillan Strategic Lead Cancer Nurse appointed in October 2018 will take a transformational approach to cancer nursing across ABMU HB, working collaboratively with the Director of Nursing, Patient Experience and Delivery Unit Nurse Directors. • The Person Centred Care Manager and Macmillan Quality Improvement Manager, both appointed in September 2018 will support the development, implementation, monitoring and evaluation of the 'person centred elements' of service improvement programmes that are tailored more to the need of the individual, while at the same time reducing duplication and waste in the system.	Macmillan Strategic Cancer Lead Nurse will take a transformational approach to cancer nursing in 2019: • Review the CNS review undertaken within cancer services in quarter 1. Extend the CNS review to collect data on CNS teams and caseload activity in quarter 2.Evaluate the efficiency and effectiveness of CNS teams in quarter 3 and Report recommendations and key themes in quarter 4.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A103	Appointment of HB Cancer Strategic Transformation Lead Nurse.	Q1					The Macmillan Strategic Lead Cancer Nurse commenced in post on the 1st October 2018				COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A104	Implement survey developed for Macmillan of patients in primary care.	Q4					Dr Jenny Brick has been appointed as the Macmillan GP Lead for ABMU HB.	Plans to establish a working group to ensure plans maintain strategic alignment with both Health Board and Primary Care strategic plans. An inaugural meeting is scheduled for the 31st October 2018 to agree terms of reference.			DoN		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A105	Identify common issues and themes of patient input of steer service development.	Q4					The Person Centred Care Manager and Macmillan Quality Improvement Manager, both appointed in September 2018 will support the development, implementation, monitoring and evaluation of the 'person centred elements' of service improvement programmes that are tailored more to the need of the individual, while at the same time reducing duplication and waste in the system. Ongoing	The Cancer Lead Nurse and Person Centred Care Manager will :- • Implement the electronic Holistic Needs Assessment (eHNA), in order to understand the needs of the person living with and beyond their cancer diagnosis. • Develop a Project Initiation Document outlining the benefits and the needs for the eHNA • Complete a Data Protection Impact Assessment and submit for review • Funding request for tablets has been agreed by Macmillan • Date for eHNA training has been scheduled for January 2019 in preparation for implementation in the key oncology areas • Lead Nurse to chair Macmillan Strategic Steering Group to oversee expression of interest bids for Macmillan funded posts.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A106	Ensure all patients are routinely informed where to access welfare benefits advice.	Q4					Macmillan, in partnership with Neath Port Talbot County Borough Council have recently appointed a Welfare Benefits Advice Manager to work with ABMU to improve referrals to the service.	As above			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A107	Establish route liaison mechanisms between primary and specialist care to meet people's ongoing and post-treatment care needs and ensure seamless handover between primary and secondary care.	Q4					Dr Jenny Brick has been appointed as the Macmillan GP Lead for ABMU HB. Plans to establish a working group to ensure plans maintain strategic alignment with both Health Board and Primary Care strategic plans. An inaugural meeting is scheduled for the 31st October 2018 to agree terms of reference.	The Strategic Lead Cancer Nurse and Person Centred care Manager will work collaboratively with tumour site teams and Macmillan GP facilitator to set up a Treatment Summary Steering group.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A108	Implement project looking at the identification of adult patients in the last year of life and facilitating their signposting to relevant services. Implement Advanced Care Planning project to improve engagement and uptake alongside education around advance care planning.	Q4					Advanced Care Planning Tool available across the HB via COIN. The Advanced Care planning team are providing awareness sessions and training around ACP across Primary and Secondary care. This includes, educational sessions in Singleton, Morriston and more targeted work in NPTH working closely with Olwen Morgan, Senior matron looking at frailty and associated pathways.	28/01/19, meeting held with Public health wales and 1000 Lives around their care Home Advanced Care Planning Initiative. 6 monthly report to End of Life care Board as agreed when project set up.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A109	To further develop the Cancer Dashboard, to allow Units to self-service cancer information to assist with their planning and performance management.	Q2					Through collaborative work undertaken by Cancer Information & Improvement and Information the CIIP was developed. Two separate views are available for USC and NUSC patients respectively to aid tracking and monitoring of patients progressing through either pathway. This visual interface of both views have been developed using information collated and input into Tracker 7. It allows the user to drill down to individual patient level, identifying the target date, current stage within the pathway and date of their next appointment. Prior to the existence of the dashboard, an excel spreadsheet was produced on a weekly basis by the Cancer Information team and distributed to the delivery units within the Health Board. The dashboard updates on an hourly basis and dramatically improve the timeliness information availability from up to seven days old to a maximum of an hour old. Demand & Capacity Modelling First OPA: Phase one was to create a suite of 'live dashboards' by which we can monitor our weekly Urgent Suspected Cancer (USC): • Referrals (demand) • Activity (number of USC patients seen at their first clinic appointment) • Waiting list (the cumulative difference between our USC demand and activity i.e. work-in-progress)				COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A110	To work in collaboration with Velindre NHS Trust, WCN, NWIS and PHW to coordinate the development of a permanent solution to the replacement of CaNISC	Q1-Q4					ABMU is engaged with the work of the Wales Cancer Network and the Cancer Implementation Group contributing to the national shaping of the work to support SCP implementation, and escalate potential risks. Ongoing. ABMU HB are piloting the new version of Tracker 7 before it is rolled out across other HB's in Wales.				MD		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A111	Work in collaboration and support the HB Clinical Lead for PREMS and PROMS.	Q1-Q4					The Health Board has recently appointed a Macmillan Strategic Lead Cancer Nurse and a Macmillan Person Centred Care Manager. The Macmillan Strategic Lead Cancer Nurse appointed in October 2018 will take a transformational approach to cancer nursing across ABMU HB, working collaboratively with the Director of Nursing, Patient Experience and Delivery Unit Nurse Directors. The Person Centred Care Manager and Macmillan Quality Improvement Manager, both appointed in September 2018 will support the development, implementation, monitoring and evaluation of the 'person centred elements' of service improvement programmes that are tailored more to the need of the individual, while at the same time reducing duplication and waste in the system. We have already initiated baseline Patient Reported Outcome Measures (PROMs) collection in one of our lung cancer clinics. This is our best opportunity to work with patients to co-produce care plans that deliver the outcomes that matter most to them and ensure we provide services that deliver 'value' for our patients. We will work closely with patients, colleagues from Hywel Dda Health Board lung cancer teams and the All Wales cancer network to extend this collection to follow up PROMs and to use this data to plan patient care and service improvement. Patient Reported Outcome Measures (PROMs) are our best opportunity to work with patients to coproduce care plans that deliver the outcomes that matter most to patients and ensure that we are providing services that deliver 'value' for our patients. Our Breast Cancer Team aspire to achieve the best possible Standards of Care and will initiate collection of PROMs data with patients to ensure patient care plans are tailored to delivering what matters most to their patients.		Compliance against the Cancer Information Framework. Audit outcomes.		DoNQ		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A112	Cancer Audit participation.	Q1-Q4					Cancer Improvement Team audits are currently being undertaken on Lung and Lower Gastrointestinal Cancer pathways against the National Optimal Pathways. Each ABMU cancer MDT has an annual audit programme, the outcomes of which are presented at their business meetings. National audit data collection is hampered by CaNISC functionality issues, as well as lack of easy access to our own data from silo systems within the ABMU data repository. Ongoing				MD		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
	A113	Opening high-quality trials including radiotherapy and surgical trials.	Q1-Q4					Funding from Welsh Government through Health and Care Research Wales continues supporting a dedicated cancer research delivery team working together with research active clinicians. • The portfolio of research trials available in the Cancer Centre remains strong. Surgical cancer trials are successfully recruiting to target. There is also an increase in planned radiotherapy trials due to open in the next quarter. • A strong portfolio of Commercial trials in the Urology and Melanoma setting continues to contribute to income generation • Research delivery staff continue to be productive members of MDT's • Research delivery staff continue to have a presence on the student nurse curriculum. Student nurses have spoke placements in the Cancer trials unit • The Research Strategy for radiotherapy has been launched and regular radiotherapy research working group meetings have been established quarterly. • Phase 1 research clinic commenced September 2018 - Funding has been received from the Wales Cancer Research centre to support a Phase 1 clinic at the Cancer Centre . This will enable cancer patients from West Wales to have initial treatment discussions relating to early phase trials closer to home. This is in partnership with Velindre Early Phase Unit Ongoing				MD		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee	Mel Simmons
HCAI Service Improvement Plan Actions	A114	Clinician audits to identify reasons for high usage and recommend and implement audit actions.	Q1					No regular clinician audits at present. Clinician audits of antibiotic prescribing have been undertaken in Singleton and POWH, but these have not specifically focussed on areas with high usage of antibiotics Paper to go to ABMU Antimicrobial Stewardship Group suggesting change from pharmacist-led bimonthly audits to clinician-led monthly audits against SSTF, using Public Health Wales audit tool. Audits will be done in all areas, as per current audit programme. No further progress.	Clinician-led audits to be taken forward by Delivery Units. Implementation of Co-amoxiclav restrictive antimicrobial policy in June 2018 has led to an increase in total antibiotic usage by DDD measurement. (This increase is accepted as a consequence of reducing the use of Co-amoxiclav, which is associated with a high risk of Clostridium difficile infection). However, the objective of reducing use of Co-amoxiclav by 50% by March 2019 is on target to be achieved.	% reduction in total antibiotic usage volumes across the Health Board (primary care to improve on 2017/18 baseline; 5% reduction in secondary care.		DPH		Lead Nurse - IPC	Infection Control Committee	Quality and Safety Committee	Delyth Davies / Janice Price
	A115	Isolate patients with unexplained diarrhoea within 2 hours of symptom onset.	Q1					In Quarter 3, the percentage of patients that had been isolated within 2 hours of unexplained diarrhoea was 50%. • 63% of patients had been isolated within 26 hours of unexplained diarrhoea. • Lack of single room availability impacts on ability to isolate.	The proportion of single rooms within each site is low. During winter months, there will be competing demands for these rooms from patients admitted with influenza. Site management teams, in collaboration with infection prevention & control, will review single room utilisation daily.	40% patients with unexplained diarrhoea isolated within 2 hours of symptom onset; 100% within 24 hours.		DoN		Lead Nurse - IPC	Infection Control Committee	Quality and Safety Committee	Delyth Davies / Janice Price
	A116	All single and multi-bedded source rooms to be emptied temporarily to enable deep cleaning and high level decontamination following identification and isolation of C difficile.	Q1					Challenge to achieve decanting source rooms to enable deep cleaning and high level disinfection. High occupancy, activity and service pressures impact on the ability to meet this standard without a dedicated decant facility on sites. To work around this, sites achieve the standard by utilising day facilities out of hours or at weekend, when service pressures allow.	Winter pressures lead to use of surge capacity. This will severely restrict the ability to utilise day facilities.	% source rooms high level decontaminated on Day 1 of identification; 100% within 5 days of identification.		DoN / COO		Lead Nurse - IPC	Infection Control Committee	Quality and Safety Committee	Delyth Davies / Janice Price
	A117	Adhere to C. difficile treatment algorithms, reflecting assessment of disease severity.	Q1					Treatment algorithms have been reviewed to reflect changes in laboratory testing method. These updated algorithms are available on the Antimicrobial Guidelines App.		% compliance with algorithms		DPH		Lead Nurse - IPC	Infection Control Committee	Quality and Safety Committee	Delyth Davies / Janice Price
	A118	Baseline audit of PVC incidence in Delivery Units. Reinvigorate STOP campaign. Adhere to best practice guidance for insertion, maintenance and removal of PVC's.	Q2					Information on PVC incidence collected in pilot wards at Morriston; this is rolling out to other Delivery Units using PDSA improvement methodologies. • Use of bundles monitored via Care Metric. Quarter 3 average compliance: - PVC insertion bundle - 76% • PVC maintenance bundle - 88%.	Delivery Units to ensure clinical staff adhere to the use of PVC bundles.	10% reduction in Staph aureus bacteraemia; data to be reported for each Delivery Unit by hospital acquired cases and community acquired cases (as identified through localised surveillance).	6% reduction (Q3 18/19= 141 compared with Q3 17/18= 150)	DPH/DoN		Lead Nurse - IPC	Infection Control Committee	Quality and Safety Committee	Delyth Davies / Janice Price
	A119	ANTT Direct Observation of Practice Assessors to competence assess clinical staff undertaking aseptic technique.	Q1					Improvement in number of clinical staff ANTT competence assessed. Training continues for Direct Observation of Practice (DOP) competence assessors.		% reduction in secondary care inpatients with PVC's on baseline in 2017/18 point prevalence survey. Increase in %age clinical staff ANTT competence assessed by Care Metrics for nursing staff; Unit Medical Directors to confirm process for medical staff).		DoN		Lead Nurse - IPC	Infection Control Committee	Quality and Safety Committee	Delyth Davies / Janice Price
	A120	Establish a programme of peer review hand hygiene audits across specialty groups within Delivery Units.	Q1					Average hand hygiene compliance for Quarter 3 – 97%. • Delivery Units commenced peer review programme.		95% hand hygiene compliance.	Metrics show hand hygiene compliance 95- 97% (Jul- Sep)	DPH/DoN		Lead Nurse - IPC	Infection Control Committee	Quality and Safety Committee	Delyth Davies / Janice Price
	A121	Audit and feedback of MRSA Clinical Risk Assessment, & implementation of audit actions.	Q2					Audit undertaken as part of localised surveillance; compliance with Clinical Risk Assessment remains variable.		% compliance with MRSA Clinical Risk Assessment.		DPH		Lead Nurse - IPC	Infection Control Committee	Quality and Safety Committee	Delyth Davies / Janice Price
	A122	Education on revised decolonisation protocol. Consider decolonisation treatment for patients requiring repeated vascular access, e.g. dialysis, chemotherapy, haematology patients.	Q2					Education programme delivered to all wards and units on secondary care sites during Quarter 2.				DPH		Lead Nurse - IPC	Infection Control Committee	Quality and Safety Committee	Delyth Davies / Janice Price
	A123	Baseline audit of urethral catheter incidence in Delivery Units. Reinvigorate STOP campaign. Adhere to best practice guidance for insertion, maintenance and removal of urethral catheters.	Q1					Audit of prevalence of urinary catheters was undertaken of the 4 acute sites in Quarter 3. PDSA improvement initiatives commenced on the 4 acute sites.. Use of bundles monitored via Care Metric. Quarter 3 average compliance: - Urinary catheter insertion bundle - 94% • Urinary catheter maintenance bundle - 94%.		5% reduction in patients with E.coli bacteraemia; data to be reported for each Delivery Unit by hospital acquired cases and community acquired cases (as identified through localised surveillance).	5% fewer cases of E.coli bacteraemia than the equivalent period 2017/18 (Health Board). NPTH DU and Primary Care and Community Services DU have achieved a greater than 5% reduction in E.coli bacteraemia compared the equivalent period in 2017/18)	DPH/DoN		Lead Nurse - IPC	Infection Control Committee	Quality and Safety Committee	Delyth Davies / Janice Price
	A124	Hand hygiene actions as above.	Q1					Average hand hygiene compliance for Quarter 3 – 97%. • Delivery Units commenced peer review programme.		Hand hygiene measures as above.	Metrics show hand hygiene compliance 95- 97% (Jul- Sep)	DoN		Lead Nurse - IPC	Infection Control Committee	Quality and Safety Committee	Delyth Davies / Janice Price
	A125	Education programme on hydration, urine sampling. Adoption of All Wales Urinary Catheter passport. Development and implementation of Blocked Catheter guidelines.	Q2					Education programme on hydration and urine sampling prepared and piloted. Ward managers to present to their staff. • Catheter passport widely used in Health Board. Some staff awaiting training which is now included in catheterisation training. Catheterisation policy revised. • Blocked catheter pathway has been included in the revised catheterisation policy		% reduction in patients with urethral catheters on 2017/18 baseline		DPH		Lead Nurse - IPC	Infection Control Committee	Quality and Safety Committee	Delyth Davies / Janice Price

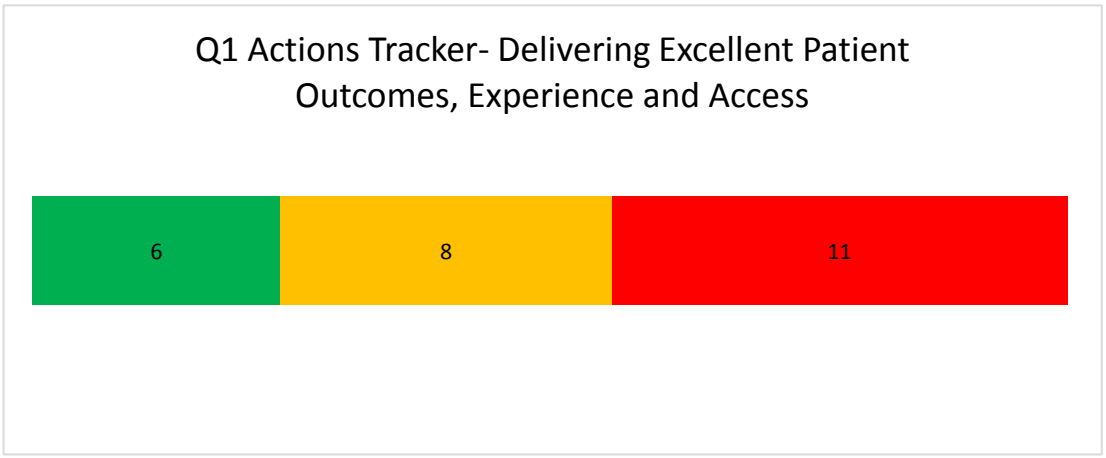
Corporate Priority		Action	Timescale	Progress Q1	Progress Q2	Progress Q3	Progress Q4	Quarterly commentary on progress	Mitigating Action for Q4 if Amber or Red	Impact Measurement: Measure	Impact Measurement: Current position where numerical measures available	Responsibility and Accountability: Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance	Lead
Delivery Plans	D1	Cancer Delivery Plan	Q4									DoS		Delivery Plan Management Leads	P&F Committee	Board	Kim Dunn
	D2	Critically Ill Delivery Plan	Q4									MD					
	D3	Diabetes Delivery Plan	Q4									DoS					
	D4	Eye Health Delivery Plan	Q4									DoT					
	D5	Heart Disease Delivery Plan	Q4									DoPH					
	D6	Liver Disease Delivery Plan	Q4									DoPH					
	D7	Mental Health Delivery Plan	Q4									COO					
	D8	Neurological Conditions Delivery Plan	Q4									MD					
	D9	Oral Health Delivery Plan	Q4									COO					
	D10	Organ Donation Delivery Plan	Q4									MD					
	D11	End of Life Care Delivery Plan	Q4									DoT					
	D13	Rare Diseases Delivery Plan	Q4									DoT					
	D14	Respiratory Health Delivery Plan	Q4									COO					
	D15	Stroke Care Plan	Q4									COO					
Corporate Objective 3- Demonstrating Value and Sustainability																	
Demonstrating Value and Sustainability Objective Measures		**Achievement of Annual Plan technical efficiency indicators:**								Quarterly benchmarking reports (Readmission, LoS, beds, DNAs, new: follow-up)							
	M29	**LoS**	Q1-4					● Combined medicine LoS has decreased by 13% on a Health Board-wide basis over the last 18 months ● Bed Utilisation Review undertaken of over 780 beds or bed equivalents in October – final report received by Executive Team in partnership with LAs ● Agreement to develop a Transformation Fund Bid for a Hospital2Home service ● ABM have continued to benchmark LOS opportunity against English and Welsh peer groups using the CHKS tool.	●Submission of Hospital 2Home bid to WG ●Establishment of a DToC action group to address levels of DToCs and MFFD across the HB	Improvement compared to Welsh peers	13% reduction in Combined Medicine LoS over the last 18 months	COO	All DUs	Head of SLR and external contracting	P&F Committee	Board	Nicola Johnson
	M30	**Theatre efficiency**	Q1-4					Performance for Morriston Hospital has improved from 74% in Qtr. 2 to 77% for Qtr. 3. Overall HB performance has increased from 68% to 72% for the same period.	Actions are ongoing in line with the Unit based Improvement Plans which are overseen by the Theatre Efficiency Board	Achieve 90%	Performance for Morriston Hospital 77% for Qtr. 3. Overall HB performance 72% for the same period.	COO	Hospital DUs	Head of Information	P&F Committee	Board	Carl Verrecchia, Gareth Cottrell
	M31	**New Ops - DNAs**	Q1-4					Outpatient appointment text reminder service implementation - review of current arrangements underway by Information / Service Improvement team – Paper prepared for discussion with COO. • Each Delivery Unit has developed a plan to address their DNA position. These plans, overseen by the Outpatient Improvement Group and led by nominated managerial leads from each delivery unit, have set out objectives to achieve the Annual Plan 2018/19 target of a reduction in the DNA rate Actions undertaken by each delivery unit lead in Q3 include: • Review patient data extract and determine compliance with Health Board DNA policy. • Teams to contact patients who DNA to determine reasons for non-attendance and to inform actions that the Health Board can take to address • Continue to explore increased opportunities for partial booking. • Adhering to best practice guidelines		Achieve 10% reduction on 2017/18 eoy baseline	0.5% reduction (Dec 18= 6.7% compared with Dec 17= 7.2%	COO	All DUs	Service Improvement Manager, NPT	P&F Committee	Board	Chris Moss
	M32	**New Ops - referrals**	Q1-4					The Annual Plan 2018/19 identified a driver to reduce the volume of outpatient referrals through increased use of e-referral systems within individual GP practices, and clinicians providing advice and feedback. The Primary and Community Services Delivery Unit is leading this piece of work, to move to 100% compliance with use of e-referral. • The 1% reduction in referrals target equates to 28,060 referrals per month. • In 2017/18 58.15% (120,846) of GP referrals were received electronically, 41.85% (86,969) received via paper. • In 2018/19 99,069 GP referrals have been received during April – September, 63.2% (62,612 via Electronic) and 36.8% (36,457) via paper.		Achieve 1% reduction on 2017/18 eoy baseline	2% increase in GP referrals (Apr- Dec 18= 160,767, Apr- Dec 17 = 157,099)	COO	All Dues	Service Improvement Manager, NPT	P&F Committee	Board	Chris Moss
	M33	**New: Follow-up ratios**	Q1-4					Updated action plans have been received from the Morriston, Singleton and Neath Port Talbot Delivery Units – and awaited from POW Delivery Unit for Q3. • These plans are overseen by the Outpatient Improvement Group which in turn reports to the Planned Care Supporting Delivery Board. Each Plan has a Managerial lead for each delivery unit and who will regularly monitored through local delivery mechanisms and the Outpatient Improvement Group. • Additional funding is being released to support short term validation reviews of the FunB lists – these are being led by the managerial delivery unit lead. • An SBAR for medium to long term sustainability solution to this reduction has been approved by the IBG for additional funding to focus on validation of FunB lists. • A Gold Command has been formed to focus on Ophthalmology Follow ups and to prepare a sustainability plan and address short term solutions for long waiting patients. • The National Outpatient Modernisation Working Group has been refreshed and actively taking forward new measures to address these pressures which are being seen across Wales. Actions include improved coding, clarification of virtual clinic patients, shared learning, and stronger information reporting by specialty		Improvement compared to CHKS peers		COO	All Dues	Service Improvement Manager, NPT	P&F Committee	Board	Chris Moss
	M34	**Redesign Service pathways using VBHc approach**	Q4					COPD business case approved by IBG, posts recruited in September. Monitoring and data requirements being agreed. TDABC data collection completed and matched to outcome measures ready to submit to All Wales Group Quarter 3 comments - Appointed into the 2 Band 6 CNS posts during October		N/A		MD	VBHc Team	Head of Value and Strategy	P&F Committee	Board	Kerry Broadhead
	M35	**Shift in service models through capacity redesign (service remodelling) programme**	Q3					• Frailty at the Front Door models developed on all three main hospital sites • ESD for COPD being rolled out across the Health Board • Innovative enabling ward in place at NPTH • Continuing focus on SAFER flow bundle • Ongoing improvements in rehab pathways and pull through to community hospitals • Investment in Older People's Mental Health community services complete (£1.6m) underpinning service remodelling • Public engagement undertaken on Tranche 1 and Board decision made to proceed with additional bed closure on a phased basis • 168 beds closed over the last 18 months across acute and mental health services • Monthly evaluation of system impacts through Service Remodelling Work stream Group • Bed Utilisation Survey undertaken on 3rd October & results presented to Executive team on 28th November. • Joint Evaluation Group took place on 30th November	● Phased completion of NPTH and Singleton schemes as agreed by Board ● Roll out of ESD for COPD ●Submission of Hospital2Home Transformation Fund Bid	N/A		DoS	Service Remodelling Work stream	Head of IMTP Dev	P&F Committee	Board	Nicola Johnson
Corporate Objective 4 - Securing a Fully Engaged and Skilled Workforce																	
Securing and Fully Engaged and Skilled Workforce Objective Measures		**Achievement of Workforce Indicators:**															
	M36	**Reduction in vacancy rate**	Q1-4					• BAPIO: The HB has participated in the 2016 and 2017 All Wales rounds and has been successful in appointing a number of doctors across a range of specialties. In 2016 36 posts were offered and 9 doctors took up post. In 2017, 27 posts were offered with 18 doctors either commenced employment or due to take up post shortly The HB is participating in the 2018/19 round and have committed 39 posts for the exercise . This has been successful and 21 posts have been offered so far. • A detailed piece of work is being undertaken to analyse every medical vacancy include consultant vacancies to understand what is planned to fill these roles or to offer them up for workforce redesign. This is ongoing and will inform a comprehensive recruitment and retention strategy for the medical workforce. The January WOD Committee will consider the draft plans. •As a result of actions being taken the last 12 months to the end Dec18 has seen FTE turnover reduce for N and M staff group by 1.94% to 7.94%, compared to the same period last year. This is a significant improvement for one of our most difficult to recruit to staff groups. This is also reflected in an improved vacancy gap for this staff group which for Dec 18 was 7.43% against the budgeted establishment, an improvement of 1.91% compared to the same period last year. • We continue to engage nurses from outside the UK to help mitigate the UK shortage of registered nurses. To date we have in our employ: • EU Nurses employed at Band 5 = 70 • Philippine nurses arrived in 17/18 & employed at Band 5 = 30 • Regionally organised nurse recruitment days which ensure we are not duplicating efforts across our hospital sites. These are heavily advertised across social media platforms via our communications team. • Eleven of our Health Care Support Workers (HCSW's) recruited to a part time	Numerous strands here. Bapio completed. Development and implementation of recruitment and Retention strategy for medical workforce ongoing work for 19/20.	Reduce by 5% on 2017/18 eoy baseline		DoHR		Asst DoHR	P&F Committee	Board	Clare Dauncey
	M37	**Reduce turnover within the first 12 months of employment**						The data shows particular decreases within Additional Clinical Services and our Nursing and Midwifery staff groups, which is particularly helpful given the difficulty recruiting registered nurses. This improvement may have partly been facilitated due to the new Nursing and Midwifery strategy published in 2017 which placed a greater commitment to a providing clinical supervision for newly qualified nurses. Furthermore, there has been a commitment to complete exit interviews for leavers in the first 12 months of employment to ensure detrimental themes are addressed. • Whilst there has been an increase in A&C leavers in the last quarter this is consistent with an increase in the same period last year. Medical and Dental has also seen a big increase in the last quarter which is due to rotation. •We are currently looking into the options available to manage exit interviews through ESR, this will enable the HB to have better access to data from staff who leave the organisation.		Reduce from eoy 2017/18 baseline	Overall Turnover has reduced over the last 5 months and remains close to 8% (FTE).	DoHR		Asst DoHR	P&F Committee	Board	Clare Dauncey
	M38	**Reduce sickness absence**	Q1-4					The 12 month rolling performance to the end of November 18 is 5.93% and represents an overall decline in performance of 0.16% since the beginning of 2018/19. Whilst long term sickness rates continue to be a challenge there has been some improvement in the last 2 months and the current performance for November 18 is 3.97% and is an improvement of 0.35% compared to reported levels at the same period last year. Absence due to anxiety /stress/depression remains the highest reason for absence and accounts for approx. a third of all absence. ACTIONS BEING TAKEN • Implementation of new all Wales Managing Attendance policy. • Commence training sessions for managers regarding the new all Wales Managing Attendance policy. • Development of a full training plan to support implementation of the new Attendance policy. • Outputs of a best practise case study conducted in three areas of good sickness performance have been shared with DU's and learnings are to be implemented via local sickness improvement plans all Units. • Development of a pilot within a selected area in order to address high absence some of which will apply learning from the above best practise case study. • Occupational Health improvement plan complete and being implemented – this includes increasing capacity for management referrals in occupational health using AHP workforce and scanning of 35 000 staff records to enable efficiency savings related to e-records and e-systems. • Continue Flu vaccination programme which to date has seen 45% of frontline staff vaccinated as 17/11/18. • Continue delivery of Mental Health awareness sessions to managers. To date		Reduce by 5% on 2017/18 eoy baseline	The 12 month rolling performance to the end of August 2018 is 5.86% (up 0.02% on June 2018). Our in month performance in Aug 18 was 5.98%, an increase of 0.01% on the previous month	DoHR		Asst DoHR	P&F Committee	Board	Clare Dauncey
	M39	**Improve PADR compliance**						Reporting figures demonstrate an increase in PADR compliance of 3.9% between September 2018 and December 2018 (63.17%- 67.13%). Action plans have been requested from the Units by the Director of Workforce and OD which incorporate how they will reach the target / increase the compliance within the Unit.		Achieve 85% target	65%	DoHR		Asst DoHR	P&F Committee	Board	Clare Dauncey
	M40	**Improve mandatory and statutory training compliance**						As of December 2018 Statutory and Mandatory Training compliance is 72.8% for the 10 UK core skills framework plus 3 local competencies. This is a 5% increase from September 2018. This equates to over 12500 competencies completed in ESR.		Achieve 85% target	73%	DoHR		Asst DoHR	P&F Committee	Board	Clare Dauncey
	M41	**Reduce variable pay**						Continued implementation of the Medical Locum cap. Imminent introduction of Locum on Duty to introduce a Medical Bank. Roll out of E job planning will commence shortly. Both projects supported by WG and TI intervention. Project staff have been recruited and will commence in post February/March 19. This will enable the rollout of both projects. • We have engaged with Kendall Block via Medics to undertake a deep dive into the ED Dept. at Morriston and to undertake a review of all junior doctor rotas across the HB to maximise efficiency in rostering all junior doctors which should lead to a reduction in agency and ADH spend. Work is underway and the results will be presented to the Exec Team on the 27th February. • Work is underway with Medics to review every long standing locum to understand if they can be replaced with a more cost effective locum and what the plans are to fill on a substantive basis. Work ongoing, recently supported by correspondence from the EMD and COO instructing the DUs to use Medics as there has been reluctance. This is tied to the emerging work on the	Projects on track but due to the need t recruit have not stated yet but this will over the next two months. KB work on track. Medics work ongoing but bolted by the EMD and COO due to the DUs reluctance to use Medacs	Reduce by 10% from eoy 2017/18 baseline		DoHR		Asst DoHR	P&F Committee	Board	Clare Dauncey
	M42	**Workforce and OD Strategy in place**	Q4					Workforce and OD will support the development of the Organisational Strategy and following its development will develop and implement a wider Workforce and OD Strategy. Draft framework of Strategy discussed at January W&ODC. Employee Relations strategy in development to support improved ER climate , including support from ACAS and review of complex cases		Strategy in place		DoHR		Asst DoHR	P&F Committee	Board	Clare Dauncey
	M43	**Improvement in staff engagement**	Q4					Patient Choice Awards - 5 Events during November and December 2018. In total 147 individuals and 32 teams were recognised. Twitter / social media count down showing appreciation of staff nominated by colleagues across the Health Board. This ran between the 1st December 2018 and was extended unit the 13th January 2019 due to number of nominations. In total 105 nominations were received and publicised. Social Media campaign of Chairmans VIP Award winners and nominees sharing learning and best practise and beginning to engage around Chairman's VIP Awards 2019. this incorporates 12 weeks of tweets and wc 14th January 2019 is week 8. Staff Survey engagement including : 5 workshops, over 140 participants and over 300 ideas generated. There have been 7 walking galleries with over 170 participants and 98 ideas for voting. Commissioning of Acas to deliver Management sessions on Bullying and Harassment for areas identified in the survey reporting 20% or over Bullying and Harassment. Tender agreed for commissioning of a 'freedom to speak up Guardian' Service. 5 concerns raised via staff experience team have been picked up and responded too in relation to behaviours and workplace culture.		Staff survey (against 2017/18 baseline)		DoHR		Asst DoHR	P&F Committee	Board	Clare Dauncey
USC Service Improvement Plan Actions	A126	Implement the local and Health Board wide programme of workforce redesign for Unscheduled Care.	Q1-Q4					Workforce capacity remains challenging and continues to be a risk and constraint particularly in ED and medical specialities, alongside nursing in key areas such as MIU and medical wards. Our ability to safely core and surge bed capacity has been particularly difficult this winter with non contract agency staff utilised at times to mitigate the risk. Some of the service redesign proposals have been implementing different roles such as physician associates, generic workers, created new band four roles to support patient flow. Some of the winter pressures funding has also supported the provision of extended cover/capacity particularly in therapy/pharmacy and support service roles. We are continuing to recruit and to try and attract staff to work within this HB but the availability of staff in some key clinical services remains an ongoing challenge.		Achievement of Workforce Improvement Indicators. Achievement of actions outlined above.		COO/DoHR		Asst COO	USC Service Improvement Board	P&F Committee	Jan Thomas
Stroke Service Improvement Plan Actions	A127	Explore opportunities to expand targeted 7 day cover through workforce redesign	Q1-4					To be taken forward through the planning process to develop the HASU. Amber status will remain until HASU plans finalised.	Ensure HASU project has clear terms of reference to include 7 day cover as part of the overall design of the clinical model.	Increase the number of generic roles.		DoHR		Assoc Dir R&S	USC Service Improvement Board	P&F Committee	Jan Thomas
	A128	Recruitment to 2nd SPR in Morriston to support 4 hour bundle.	Q2					6 additional middle tier medical staff have been appointed at Morriston.	Appointments made to Unit - but other vacancies are reducing the impact of these appointments with staff working down into other posts to cover duties.	SpR appointed		COO		Assoc Dir R&S	USC Service Improvement Board	P&F Committee	Malcolm Thomas
	A129	Continue staff training and awareness sessions of stroke pathway	Q1-Q4					SLT training sessions have been undertaken in Morriston • The new middle tier of medical staff (referred too above) are in the process of receiving thrombolysis training.	ED staff have undergone Swallow assessment training	Evidence of staff who have received stroke training awareness sessions.		DoHR		Assoc Dir R&S	USC Service Improvement Board	P&F Committee	Malcolm Thomas

Corporate Priority	Action		Timescale	Progress				Quarterly commentary on progress	Mitigating Action for Q4 if Amber or Red	Impact Measurement		Responsibility and Accountability				Lead
				Q1	Q2	Q3	Q4			Measure	Current position where numerical measures available	Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance	
	A130	Continue training and awareness in communication skills and advance care planning.	Q1-Q4							Improve End of Life Care		DoT		Assoc Dir R&S	USC Service Improvement Board	P&F Committee	Malcolm Thomas
HCAI Service Improvement Plan Actions	A131	Review funding allocation for DU rapid Response Teams to undertake the cleaning and decontamination of all equipment and environments, releasing nurses' time for patient care activities.	Q2					No further progress made	Review meeting with Head of Support Service, Assistant Director of Nursing IPC and Consultant Microbiologist in February	N/A		DoN	IPC Team	Head of Nursing, IPC	Infection Control Committee	Q&S Committee	Delyth Davies / Janice Price
	A132	Develop a business case for consideration by IBG for a 7 day Infection Control Service, that reflects the Delivery Unit structures and provides a sustainable workforce to support work streams of the HCAI Collaborative Drivers.	Q2					No progress made. Impact of Boundary Changes to be worked through.	Impact of Boundary Change will result in reduced budget. To review as part of new organisation after April 2019	Business case developed.		DoN	IPC Team	Head of Nursing, IPC	Infection Control Committee	Q&S Committee	Delyth Davies / Janice Price
	A133	Review outreach service models to provide appropriate and safe urinary catheter care at home.	Q2					Continence service training for community staff and care home staff, which includes catheter care. Catheter care is also supported by the adoption of the Catheter passport.	Impending Boundary Change restricts further development at present.	Models reviewed.		DoN	IPC Team	Head of Nursing, IPC	Infection Control Committee	Q&S Committee	Delyth Davies / Janice Price
	A134	Antimicrobial stewardship training across the Health Board.	Q1					Antimicrobial stewardship training sessions provided on junior doctor induction by antimicrobial pharmacists; other sessions provided when requested.		Training rolled out.		DoN	IPC Team	Head of Nursing, IPC	Infection Control Committee	Q&S Committee	Delyth Davies / Janice Price
	A135	Consider alternative models for antimicrobial review in relation to the Focus element of "start Smart, Then Focus", e.g. nurse/pharmacist prescribers.	Q2					Completion of 48-72 hour review section is audited bimonthly at present. Compliance remains poor, • November 2018 audit result IV antibiotics >72 hours - 42% of antibiotic prescriptions (target ≤ 30%)	Medical Directors receive reports and have committed to dealing with non-compliance	Audits to be completed.		DoN	IPC Team	Head of Nursing, IPC	Infection Control Committee	Q&S Committee	Delyth Davies / Janice Price
Corporate Objective 5 - Embedding Effective Governance and Partnerships																	
Embedding Effective Governance and Partnerships Objective Measures	M44	**Delivery of the financial plan and agreed recurrent savings programme through the R&S Programme**	Q4					Delivery has been managed through work streams aligned with the Recovery and Sustainability Programme • Month 9 tracker indicates that most areas are not delivering against the plans. • Mitigating actions have been agreed to support the achievement of control total	A six month review of actions was completed in October and further key actions identified for year end A new work stream has been established to bring together all of the elements of medical workforce actions including a detailed review of junior doctor and ED rota's; implementation of locum on duty and e-job planning and other actions Units have been asked to identify mitigating actions to offset non delivery of savings and these are being managed through regular Performance, Quality and Finance meetings	Savings assessment		DoF	R&S Programme Board	Deputy Dir R&S		P&F Committee	Dorothy Edwards
	M45	**Achievement of the agreed financial control total in 2018/19 and continued development of a plan to achieve financial breakeven**	Q4					YTD positon at the end of month 9 is £1.3m over the £10m control total target based on 9/12th of £20m less £2.5m of the additional WG support. This reflects the non-delivery of required savings and operational pressures, which has been partially offset by the release of identified mitigating opportunities, including slippage on some committed reserves and other recurrent and non-recurrent opportunities. There are plans to deliver the £10m forecast position. • Plan to deliver £10m control total in place and being robustly monitored. • Underlying position and impacts continue to be developed.		Financial control total		DoF		Asst DoF		P&F Committee	Sam Lewis
	M46	**Enabling and supporting plans delivering required improvements (to achieve financial control total)**	Q1-4					Weekly monitoring dashboard. • Quality, Performance and Finance meetings to support planned delivery. • Weekly Action Plan updates and continued deep dive activity.		CIP Tracker achievement of plans		DoF		Asst DoF		P&F Committee	Sam Lewis
Planned Care Service Improvement Plan Actions	A136	Agree joint outsourcing package and implement commissioning of the activity agreed LTA in place for both organisations as a commissioner.	Q1-4 Q1-4					The outsourcing programme was not delivered fully in Q3 due to the inability of the main Provider to fulfil its contractual obligation. The contract was retracted and coverage for the full capacity lost in Q3 and planned capacity for Q4 has been secured across multiple providers, mitigating any risk of sole reliance on a single point of delivery. Outsourcing in line with the new contracts is well underway and will continue to the end of March 2019.		Contracts in place Commission of activity underway.		COO		Asst DoS	JRPDC	Board	Darren Griffiths
	A137	Agreed LTA in place for both organisations as a commissioner.	Q1					Signed LTAs in place across all South Wales Health Boards as both Providers and Commissioners		Signed agreed documents		DoS/DoF		Asst DoS	JRPDC	Board	Darren Griffiths
	A138	Agree models of service where workforce can be shared.	Q2					Regional planning discussion are considering options for workforce sharing. To date there are examples in endoscopy, dermatology and vascular where joint		Consultants and other staff working across boundaries.		DoS/COO		Asst DoS	JRPDC	Board	Darren Griffiths
	A139	Agree repatriation pathways in place for key pressured services, vascular, cardiology (unscheduled care benefits also)	Q2					Progress made in vascular and cardiology services for patient flow as a result of regional planning discussions.		Signed off pathways in place and operational		COO		Asst DoS	JRPDC	Board	Darren Griffiths

RAG Rating	Number of Actions	%age
Red	20	11
Amber	97	52
Green	65	35
Not rated	3	2
Total	185	100


Q3 RAG Rating Action Tracker- Summary of Achievement of Corporate Objective Measures
Promoting and Enabling Healthier Communities
Delivering Excellent Patient Outcomes, Experience and Access
Demonstrating Value and Sustainability
Securing a Fully Engaged and Skilled Workforce
Embedding Effective Governance and Partnerships
Total
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%


Q1 Actions Tracker- Promoting and Enabling Healthier Communities
3
0


Q1 Actions Tracker- Delivering Excellent Patient Outcomes, Experience and Access
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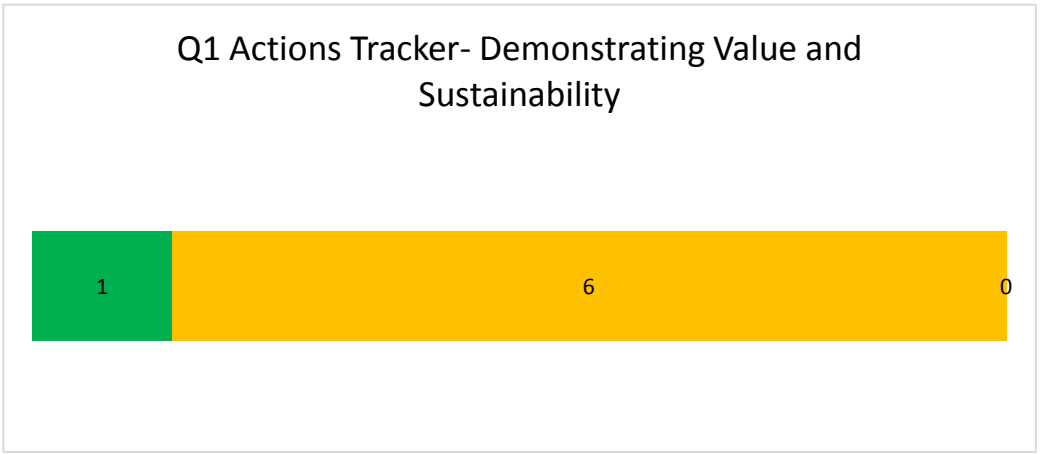
Q1 Actions Tracker- Demonstrating Value and Sustainability
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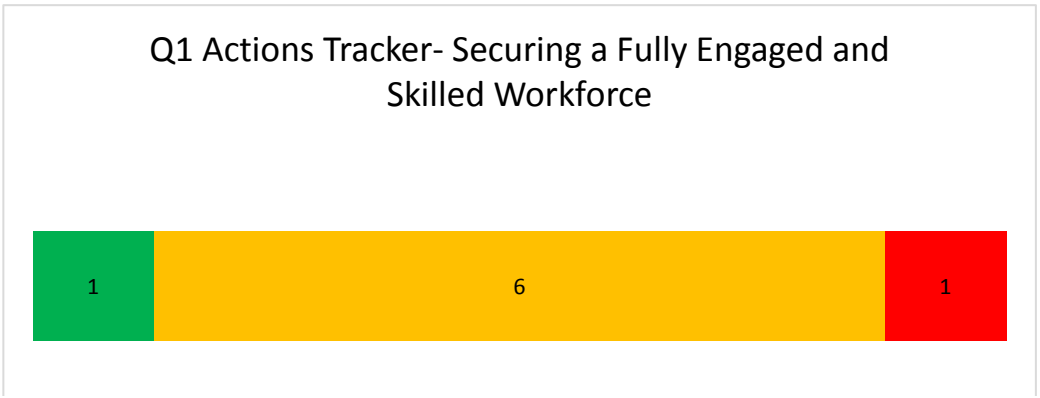
Q1 Actions Tracker- Securing a Fully Engaged and Skilled Workforce
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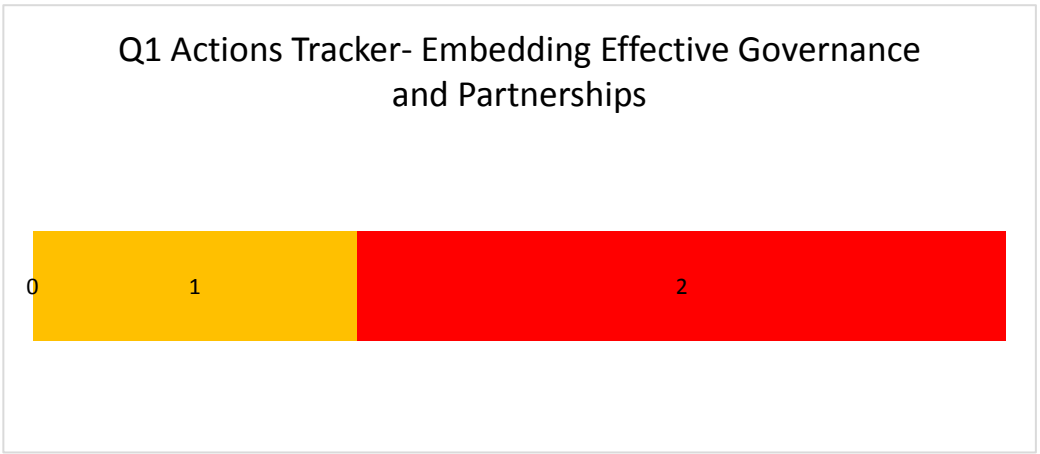
Q1 Actions Tracker- Embedding Effective Governance and Partnerships
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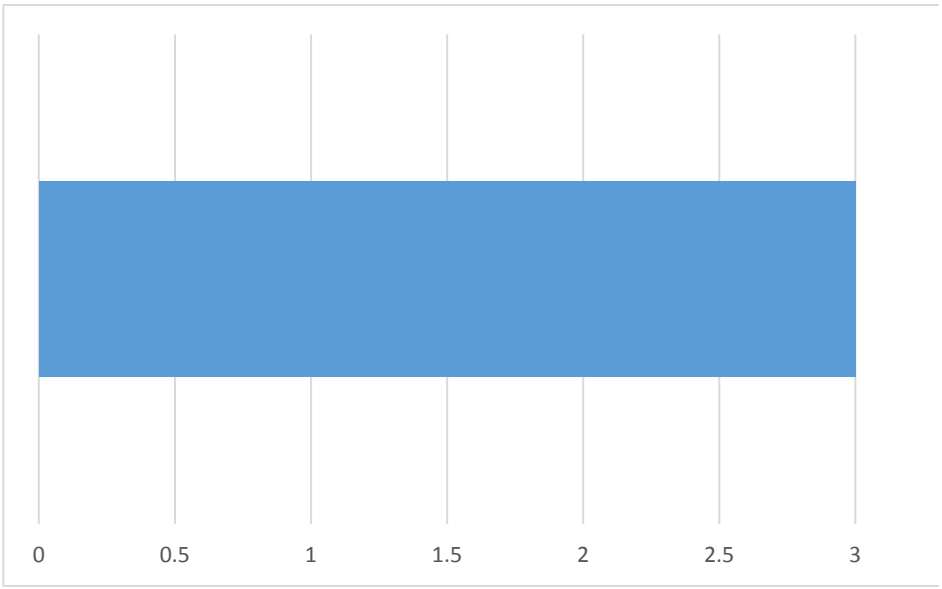
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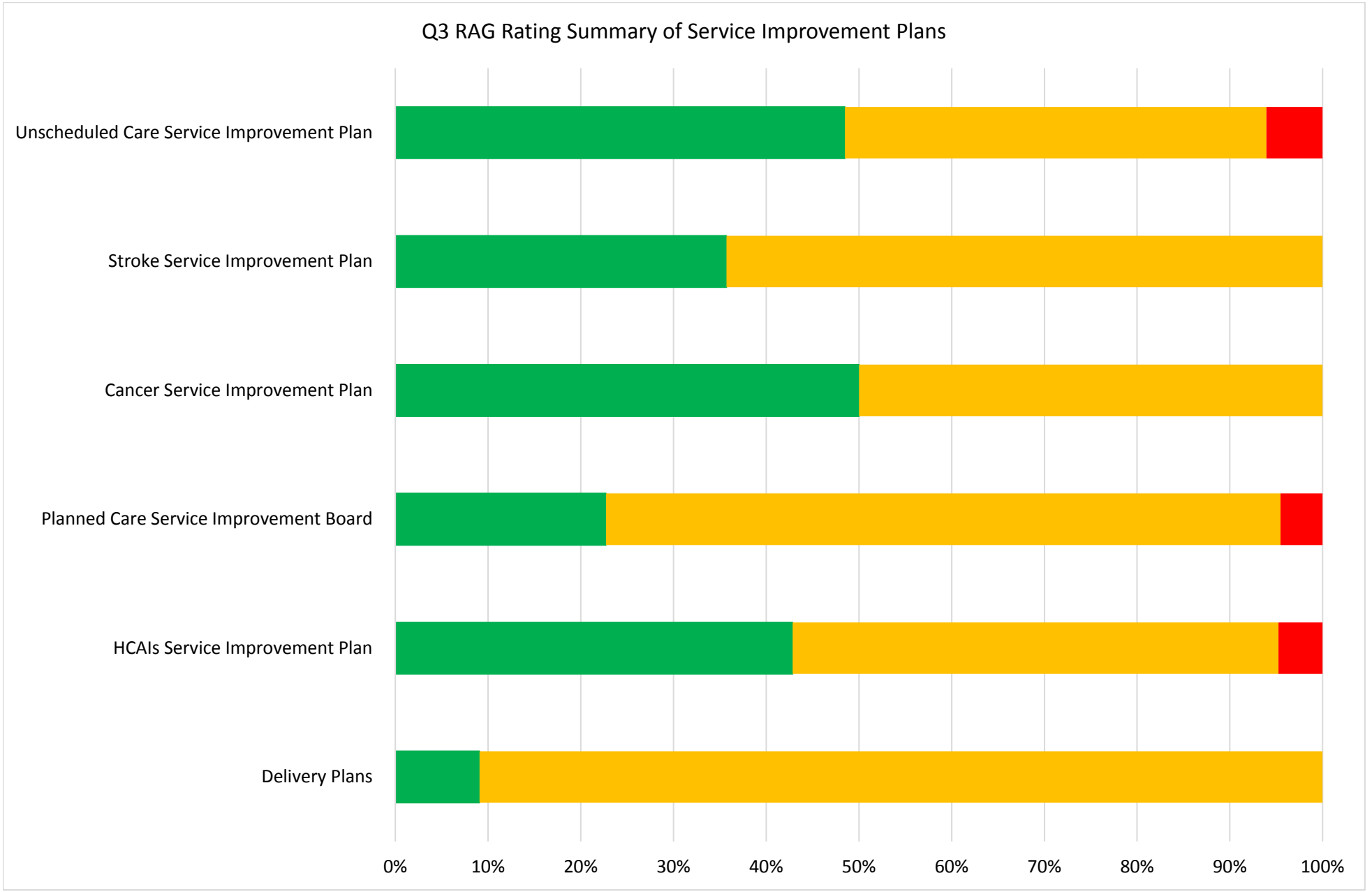
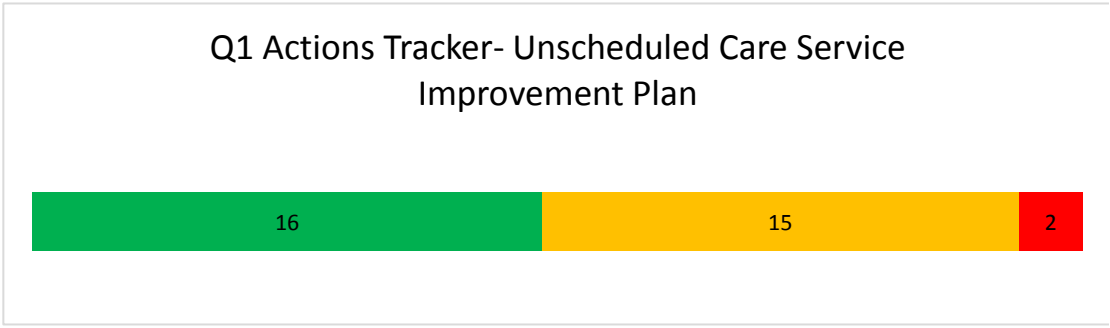

Q3 RAG Rating Summary of Service Improvement Plans
Unscheduled Care Service Improvement Plan
Stroke Service Improvement Plan
Cancer Service Improvement Plan
Planned Care Service Improvement Board
HCAIs Service Improvement Plan
Delivery Plans
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%


Q1 Actions Tracker- Unscheduled Care Service Improvement Plan
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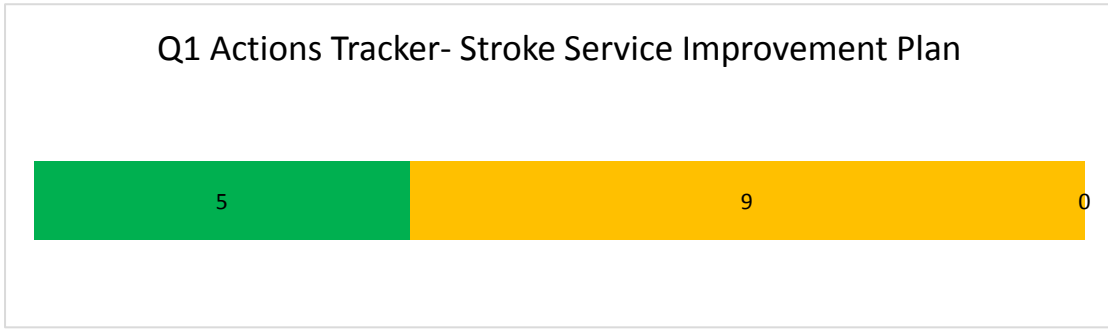
Q1 Actions Tracker- Stroke Service Improvement Plan
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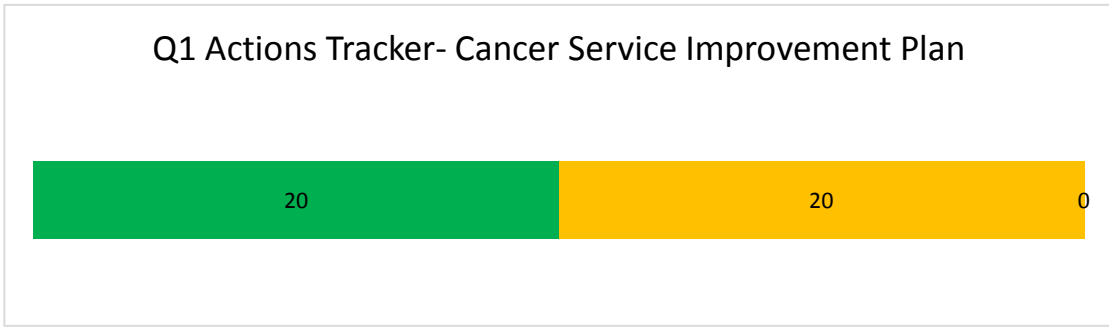
Q1 Actions Tracker- Cancer Service Improvement Plan
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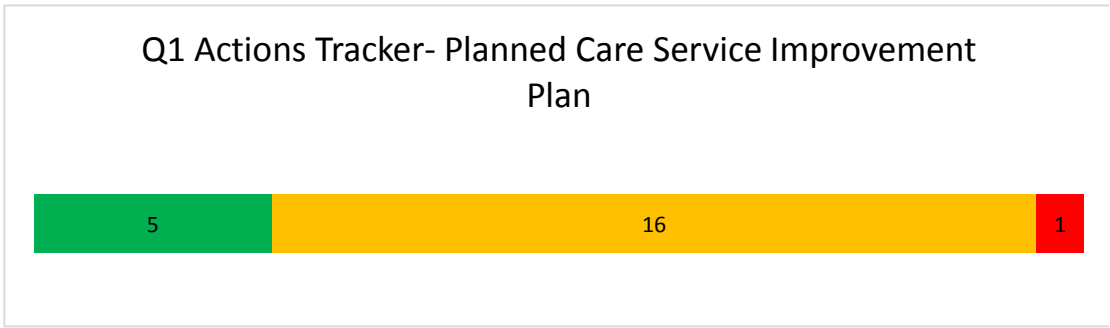
Q1 Actions Tracker- Planned Care Service Improvement Plan
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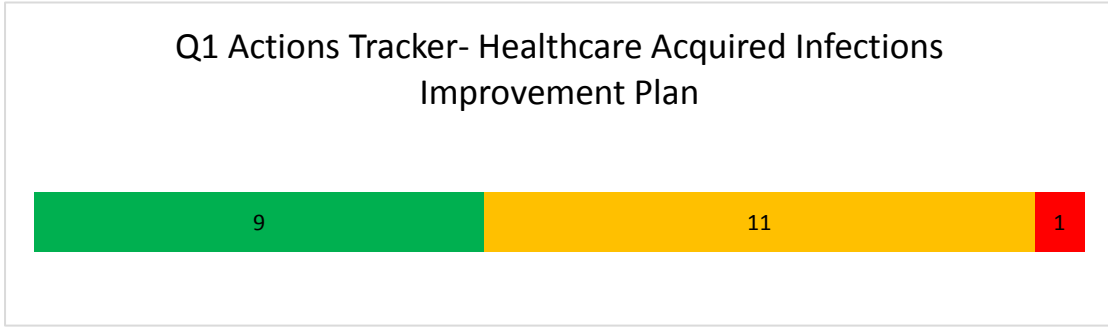
Q1 Actions Tracker- Healthcare Acquired Infections Improvement Plan
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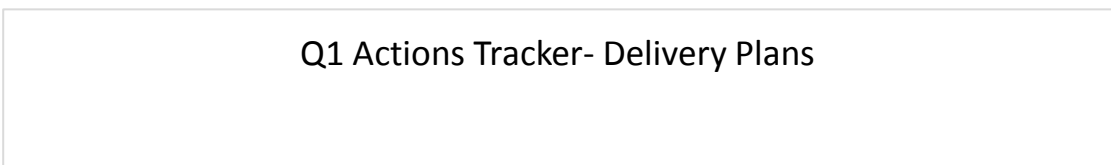
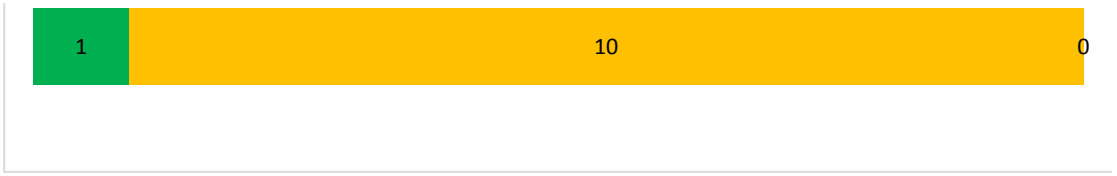

Q1 Actions Tracker- Delivery Plans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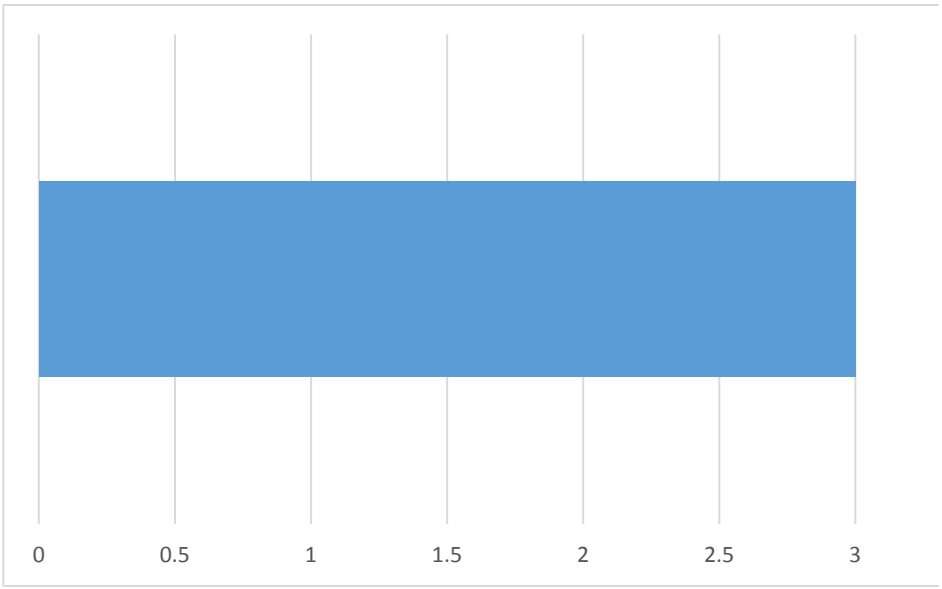
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