Meeting Date	**29th November 2018**	**Agenda Item**	**3i**
Report Title	Report on the Implementation of the Annual Plan 2018/19 - Quarter 2		
Report Author	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 2 2018/19. The report has been considered by the Performance and Finance Committee at its November meeting.		
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	The Board is asked to: - • ENDORSE the Quarter 2 report on the implementation of the Annual Plan 2018/19; and, • NOTE it will be submitted to Welsh Government for assurance purposes.

QUARTER 2 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 Objective and actions set out within the Annual Plan 2018/19, as at the end of Quarter 2.

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

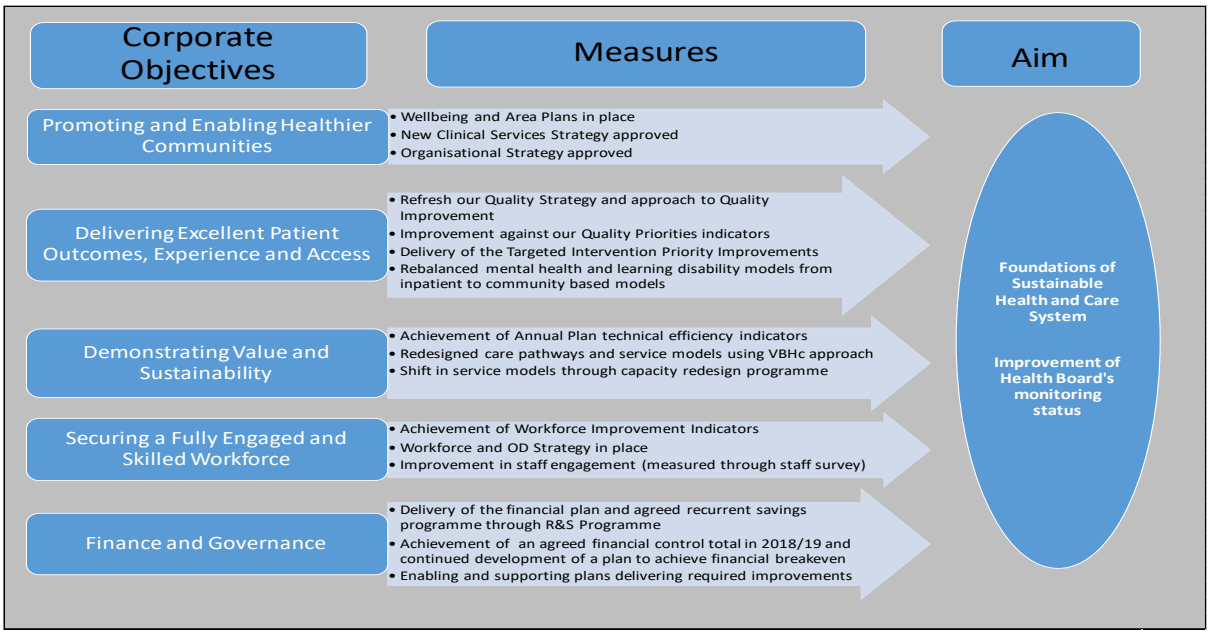
The Annual Plan implementation monitoring report for Quarter 2 is attached at **Appendix A** for the Board's consideration. **Appendix A** is the detailed internal monitoring return and the narrative explanation and summary commentary is included for ease of reference in this covering paper. This report should be considered in tandem with the main Health Board performance report.

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

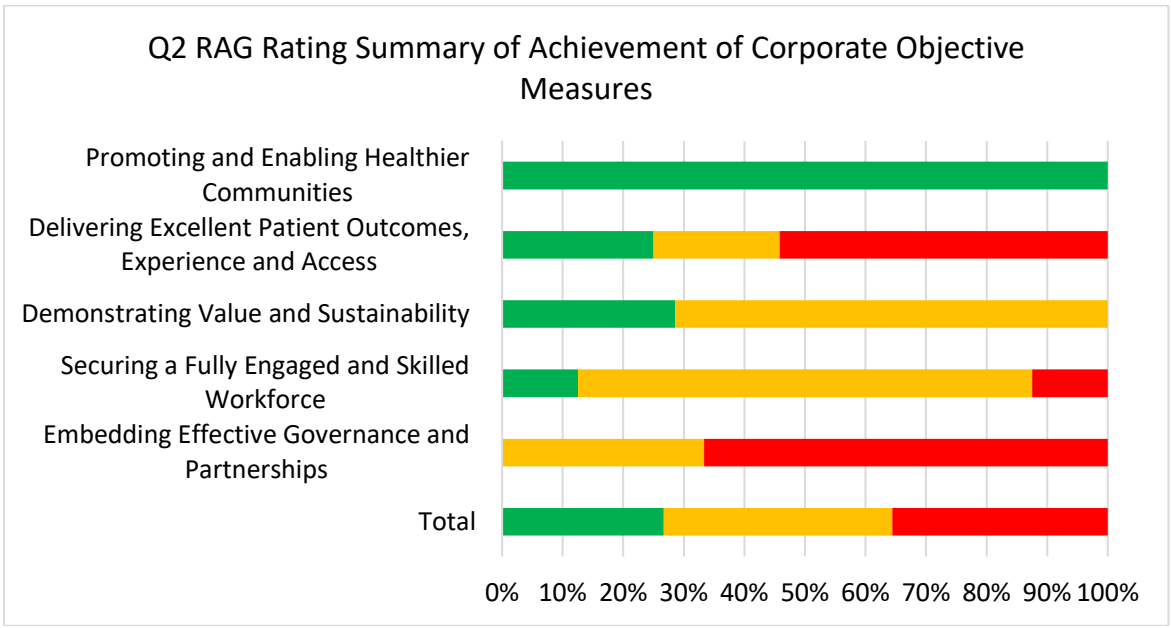
The Annual Plan 2018/19 outlined our Corporate Objectives to achieve our overall Aim of setting the foundation for future sustainability and improvement of our monitoring status. High-level measures were described to be able to monitor success in achieving the Objectives as shown in the diagram below.



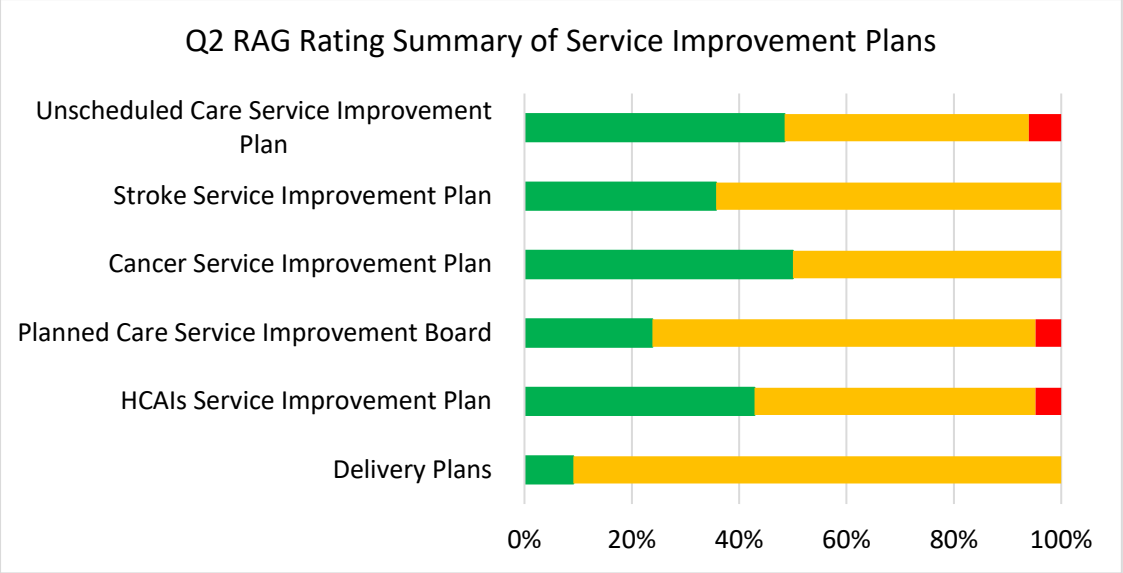
The detailed monitoring report is structured to report on our Corporate Objectives using colour-coded headings for each Corporate Objective as follows:

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 at the end of Quarter 2 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 which included 140 detailed actions. 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, patient outcomes and value. However at the end of Quarter 2 we were off-track with achieving a number of our key objectives for delivering improved patient access and financial targets.

3.2 Detailed Assessment of Achievement of Plans

The monitoring shows that at the end of Quarter 2 there were 64 plans which were either on-track or completed (35%) and 20 off-track plans (11%). The remainder are in progress.

RAG Rating	Number of Actions	%
Red	20	11
Amber	98	53
Green	64	35
Not rated	3	2
Total	185	100

The 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.

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	• We have Wellbeing and Area Plans in place. • We are on-track to complete our Organisational Strategy and Clinical Services Plan for Board approval in January 2019. • There is good progress with achieving our targets for immunisations and vaccinations. • We are continuing to embed health literacy and approaches such as making Every Contact Count to improve health and related outcomes. • In cancer services we have completed our demand/capacity work for endoscopy and pathology. • The Human Papilloma Virus vaccination is being rolled out to boys (prevention of head and neck cancers). • Prevention of infections is proceeding through promotion of hydration and other actions to reduce the use of catheters and reduce antibiotic usage.
Delivering Excellent Patient Outcomes, Experience and Access	• The Health Board is continuing to make progress in reducing harm from falls. • With regard to targeted Intervention priority targets we achieved the following in Quarter 2: o We achieved the target for the responding to red emergency calls; o We achieved two of the four stroke measures; 4hrs to admission to an Acute Stroke Unit and CT Scan within 1 hour ; and, o We reduced our infection rates for c.difficile and E.coli compared to the same period last year. • In unscheduled care we: o Continued to maximise the use of the 111 service and Community Resource Teams; o Implemented the agreed joint ambulance initiatives to reduce admissions; o Continued to develop ambulatory care and anticipatory care models; o Implemented psychiatric liaison service measures as well the ECIP plans for Morriston and POWH; o Continued to implement the SAFER flow bundle;

	○ Continued to rollout Comprehensive Geriatric Assessment, early supported discharge models and our Service Remodelling programme across older people's services. • In stroke services we: ○ Confirmed the thrombectomy pathway; and, ○ Promoted the FAST model for identification of strokes. • In planned care we: ○ Rolled out the use of e-referral; ○ Developed the Theatre Efficiency Board; and, ○ Agreed full year capacity plans to deliver the year-end position. • In cancer services we: ○ Implemented detailed demand/capacity plans for endoscopy and gastroenterology; ○ Expanded the Rapid Diagnostic Centre; ○ Reviewed and implemented new pathways in POWH urology services; ○ Implemented changes to the post-menopausal bleeding pathways; ○ Put in place Support and Challenge Panels for specific tumour sites and agreed action plans for each Unit and tumour site level; ○ Continued participation in the Peer Review process and cancer Audits; ○ Developed the cancer dashboard to provide robust performance monitoring information across the detailed cancer pathways; ○ Appointed a Cancer Strategic Transformation Lead Nurse; and ○ Continued our programme of clinical trials. • To reduce healthcare acquired infections we: ○ Established a programme of hand hygiene audits; ○ Audited use of the MRSA Clinical Risk Assessment; and, ○ Undertook education on the decolonisation protocol.
Demonstrating Value and Sustainability	• We are on-track to achieve a 1% reduction referrals through use of e-referral and working with Clusters.
Securing a Fully Engaged and Skilled Workforce	• We have reduced our staff turnover within the first 12 months of employment, with a particular decrease in the Nursing and Midwifery. • In stroke services we have recruited 6 additional middle tier doctors at Morriston. • We have undertaken antimicrobial stewardship training across the Health Board.
Embedding Effective	• We have agreed a joint outsourcing package and

Governance and Partnerships	have signed Long Term Agreements in place across all South Wales Health Boards.

3.2.2 Actions which are off-track

Detailed feedback on the summary of the 20 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 as to whether they are still the right things to do as follows, and these ae 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	Increase flu immunisation uptake for people with chronic conditions and people over 65	There has been a delay in the supply of the vaccines due to changes in the vaccines for the over 65s and those with chronic conditions which were centrally recommended. This has adversely impacted on achievement of the trajectory for vaccine uptake. As more supply becomes available it is anticipated the trajectory will start to improve from November onwards.	Q3
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
	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	Performance in September was 77.5% against the IMTP profile of 87.8% and was under profile across the quarter. In September 2018, 96.1% of patients were admitted, discharged or transferred from our ED's within 12 hours but 588 patients stayed over 12 hours in our Emergency Departments (ED's) during September 2018. In the same period attendances decreased by 4%. Our improvement actions include: • Implementation of GP expected pathways and improved access to speciality services with additional hot clinics (Morriston). • Embedding the safety huddle approach which will strengthen daily patient flow processes (Morriston). • Expanding the opening hours of the medical day unit in Singleton and fully implement the integrated older persons service model at this hospital. • Systematically focussing on improving the minor's workstream in the ED at Princess of	Q3
	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	Wales hospital. • Developing the early supported discharge service which commenced in NPT hospital in mid-September. We will also be implementing our winter assurance plan for 2018/19 and reviewing our discharge improvement programme of work in light of feedback recently received from the Delivery Unit's complex discharge audit which was undertaken in August. This feedback will also be considered alongside the findings of the inpatient bed utilisation survey which was undertaken in Swansea and NPT hospitals in early October.	
	Number of ambulance handovers over one hour	Although our response to red calls was significantly better than the national target, our 1 hour ambulance handover performance deteriorated during Quarter 2 to 541 patients reported in September. In the same period 273 fewer patients (a 7.6% reduction) were conveyed to our hospital front doors by ambulance in September 2018 when compared with September 2017. This is a reflection of the joint work programme which is in place between the Health Board and WAST to reduce conveyance rates to hospital by an emergency ambulance. Our improvement actions include: • Continuing to work closely with WAST to ensure that patients are directed to the most appropriate service or pathway of care that best meets their needs and as a result the number of patients conveyed to hospital by ambulance is reducing. • Continued development of pathways, models of care and the workforce within available resources to reduce health care professional requests for an emergency ambulance response. There was an 8.7% reduction in the green/HCP call conveyance category in September 2018 when compared with September 2017. • Implementation of the management recommendations provided in response to the WAST internal audit report on hospital handover. A progress update was provided to the USC board in October 2018, and the majority of recommendations applicable to ABMU HB have been implemented in line with the agreed plan. • The Health Board has funded paramedic posts in the out of hours service which will enable 24/7 paramedic cover to be provided to assist and support this service from 5th November 2018.	Q3
	Assessed by a Stroke Specialist Consultant Physician (< 24 hrs)	In September assessment by a Consultant was 69% for the Health Board as a whole and we did not achieve the target for thrombolysis door to needle time (11%) which remains very variable. Our improvement actions include:	Q3
	Thrombolysis door to		

	needle <= 45 mins	• Additional Medical appointments have taken up post during August and September – although there remain gaps in overall out of hours cover. • Weekly multi-disciplinary meetings in Morriston and POWH to review individual patient pathways and to identify opportunities for improvement. <u>Morriston</u> • The additional medical staffing will allow 2 registrars being on duty from 10pm-9:30am mid-week, and on weekends there will be 2 registrars providing cover from 9am - 2:00am the next morning. One registrar focuses on the ward cover and the other provides a presence in A&E for all number of conditions but including Stroke. When there are two middle grades on a night shift or weekends, it is proposed that one of them is nominated as the stroke champion. Discussions on the Thrombolysis Champion role amongst the medical OOH team are underway and scheduled to be completed by the end of November. • A Business case for a Stroke Retrieval team to be considered by local management team once completed, and then included within the IMTP / IBG for investment. • Swallow screening training with ED staff has been completed with the aim to improve the response / performance and quality of service to patients with a potential stroke. Monitoring of this will be reflected in the monthly reports. <u>Princess of Wales</u> • The five Task and Finish groups continue to undertake actions to improve their performance • Clerking procedures in ED have changed with patient transfers now not being delayed because of clerking arrangements – where necessary clerking is undertaking on the ward and the patient transferred in a more timely fashion. Performance in accessing a Stroke bed should therefore improve and not delayed because they were awaiting a clerking in procedure to be completed in ED. • The Unit is developing a case for an early Supported Discharge service. <u>ABMUHB wide</u> • Ongoing planning in terms of working towards the “Hyper-acute Stroke Unit” model. Non recurrent funding secured from national funding to fund a dedicated project manager to support this work. Appointment has been made and the successful applicant has started. • The Morriston Business case for an Early Supported Discharge service has been considered by the IBG – with further work required and alternate sources of funding – non recurrent and recurrent being considered	

	The %age of patients waiting less than 26 weeks for treatment The number of patients waiting more than 36 weeks for treatment	In September 2018 there were 89 patients waiting over 26 weeks for a new outpatient appointment. This was an in-month reduction of 16 compared with August 2018 (105 to 89) and is mainly contained within Ophthalmology (58%). There were 3,381 patients waiting over 36 weeks for treatment in September 2018. 97% of the patients waiting over 36 weeks are in the treatment stage of their pathway. 1,497 patients are waiting over 52 weeks in September 2018 which is 9% less than in September 2017 and 1% less patients than August 2018. The overall Health Board RTT target remained stable in September 2018 at 89.1%. Our improvement actions include: <u>Morriston</u> • Agreement for outsourcing a further 200 orthopaedic cases in addition to the 200 cases within the RTT delivery plans. Capacity has been secured and outsourcing has commenced. • A solution to satisfy fire safety compliance for a mobile staffed theatre unit adjoining the hospital corridor from a located court yard has been found. Final discussions are taking place and the lead in time confirmed so that a start date can be confirmed by the end of November. • A theatre list has been established at NPTH for two joints per week commencing 19th November, with potential to increase. • Training to increase the number of theatre scrub staff is ready to commence from November. <u>POWH</u> • A paper is being prepared for Executive Team to consider a time-limited enhanced remuneration system for Orthopaedic theatre nursing staff to enable additional working outside core hours by end November. • Discussions with Cwm Taf regarding their offer to backfill lists are concluding. The outcome will be known by the end of October and if feasible start dates will be agreed.	Q3
	The number of patients waiting more than 8 weeks for a specified diagnostic test	There were 762 patients waiting over 8 weeks for reportable diagnostics as at the end of September 2018. (123 Non Obstetric Ultrasounds (NOUS), 4 Cystoscopy, 635 Cardiac tests). Our improvement actions are: • The 123 NOUS patients at the end of September are as a result of continued reduced workforce capacity amongst the Head & Neck sub-specialty Radiologists and Sonographers. Recent analysis undertaken is showing a growth in demand for total ultrasounds of 30 per week. Further analysis is underway to break this down to the sub-speciality of Neck and referral patterns to address potential hot spots. This work will	Q3

		conclude by the end of October. Outsourcing is in place to improve the breach numbers. • There is an ongoing handful of cystoscopy breaches in Princess of Wales as a result of significant sickness absenteeism amongst the small consultant body. Locum consultants continue to be sourced and appointed however retaining these personnel is proving challenging. Discussions with Cwm Taf University Health Board are taking place to scope potential to support the Urology service. • A case for a Health Board wide solution for Cardiac CT and MRI has been submitted. The plan requires scrutiny and testing through the October RTT meeting prior to a decision on its implementation. The waiting times breaches for the suite of newly reportable cardiology diagnostics (excluding Cardiac CT and MRI) will clear at the end of Quarter 3 and be sustained.	
	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 had 66,629 patients waiting for an outpatient follow-up at the end of September and did not deliver against its profile at the end of Q2. In-month performance has slightly improved for both follow up booked and not booked. Our improvement actions include: • 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 is in final preparations for consideration by the IBG. The Document is being developed by the Project Lead with the support of the delivery unit leads. • Internal Audit have completed their review of progress against the WAO recommendations. Their report has been received – an action plan is in preparation to address their recommendations and will be available in November. A level of investment has been agreed to address the increasing numbers of potential erroneous entries on the FunB lists and to clean this profile. This will be led by the Outpatient Improvement Group with the support of the delivery Unit management leads through to the end of the financial year. • 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.	Q3
	The percentage of patients newly diagnosed with cancer, not via the urgent route, that started definitive	NUSC performance for September 2018 is 96% (6 breaches) and USC performance for September 2018 is 83% (25 breaches). Improvement actions being taken include: • Full implementation of the Post-menopausal bleeding pathway with aim to improve waiting times for diagnostics, which will reduce overall wait from referral to treatment.	Q3

	treatment within (up to and including) 31 days of diagnosis (regardless of referral route) 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	The new clinic model will be implemented in November 2018. • All theatre lists reviewed. Additional weekend WLI theatres arranged to accommodate USC and NUSC patients.(it varies but Gynaecology for six weekends) • Additional endoscopy lists undertaken to keep waits to a minimum • Adverts for Consultant posts in Breast Radiology, Gynae-Oncology Surgery and Oncology have been placed. • Additional resource of a Consultant Radiographer who has moved to the area for two days a week in support of the Breast Service, to work 1 day from Singleton and 1 day from Neath which will improve sustainability of the diagnostic clinics and reduce lengthy first assessment waits. • Building on the current portfolio of Demand and Capacity work, further analysis has been undertaken in support of Endoscopy; Gynaecology and Radiology; and is being used by the Services in development of business plans. • Review of the practice around authorisation of Annual Leave of medical staff. Medical Director has asked that the Consultant Groups agree staffing levels to ensure sufficient demand is available during peak holiday periods. • Additional resource in cancer tracking posts at POW has been agreed and is being recruited.	
	Achievement of S. Aureus bacteraemia trajectory (10% reduction)	Our improvement trajectories are based on improvement on the 2017/18 position and C.difficile and E.coli infection rates in Q2 improved on Q2 the previous year but there was a 9% increase in MSSA bacteraemias on the same period last year. Our improvement actions include: • Delivery Units (DU) are to focus on improving compliance with the number of staff that have completed Aseptic Non Touch Technique (ANTT) training - 10% improvement on staff trained by 31 March 2019. • It is possible now to record ANTT competence on ESR; the accuracy of this system is dependent on Delivery Units sending lists of staff to the member of staff that can update ESR. • During first month in post (October 2018), IPC Quality Improvement (QI) Matron will meet with Delivery Units to scope out QI PDSA programmes being undertaken and identify opportunities for shared learning and improvement. • The IPC Team to undertake Point Prevalence Survey of invasive device use in 6 hot spot wards, and compare against incidence identified in the 2017 PPS - by 31.10.2018. The 2018 prevalence will be used as a baseline prior to implementation of PDSA improvement methodologies	Q3

	Ensure Minors streams meets 4 hour standard.	Our minors stream performance was affected by the majors demand in Q2. Plans a rein place to increase focus on the management of minors patients within the Emergency Departments during Q3 to ensure pathways and processes are established to deliver 4hr performance sustainably.	Q3
	Extend the Planned Care Programme to additionally cover OMFS, Gynaecology and Vascular Surgery as part of the roll out programme.	The national programmes are delayed and have not therefore been rolled out. We are continuing our own improvement work in all three of these areas.	-
Securing a Fully Engaged and Skilled Workforce	Reduce sickness absence	The 12 month rolling performance to the end of August 2018 was is 5.86% and represents an overall decline in performance of 0.09% since the beginning of 2018/19. Long term sickness rates continue to be a challenge with rates at 0.21% higher than the same period last year. Absence due to anxiety /stress/depression remains the highest reason for absence and accounts for a third of all absence. Our improvement actions are: • Share outputs of best practise case study conducted in three areas of good sickness performance and develop plan for implementation of learnings across all Units. • Roll out of LTS pathways for MSK conditions to help guide managers in managing common absence conditions. • Develop an implementation plan for the revised all Wales Managing Attendance policy • Develop improvement plan for occupational health services based on data analysis and engagement with clinical team. • Complete roll out of training for this year's Flu Champions • Continue delivery of Mental Health awareness sessions to managers. • Continue further delivery of Work related stress risk assessment training for managers.	Q3
	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	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 postholder will advise if this action remains valid in Q4 as she assesses the Health Board's capacity to address the infection control issues.	Q4

	streams of the HCAI Collaborative Drivers.		
Embedding Effective Governance and Partnerships	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 6 tracker indicates that most work areas are not delivering against planned profiles and mitigating actions have been agreed to support the achievement of control totals	Q4
	Achievement of the agreed financial control total in 2018/19 and continued development of a plan to achieve financial breakeven	The year-to-date position at the end of Month 6 is £2.39m over the £20m control total target based on 6/12ths of £20m. 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. A plan to deliver the £20m control total in place and being robustly monitored and the underlying position and impacts continue to be developed.	Q4

4.0 Assurance and Governance

The report will be 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.

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

The Board is asked to:

- ENDORSE the Quarter 2 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 A. Annual Plan Progress Report Qu2 2018/19

Actions and timescale									Impact Measurement		Responsibility and Accountability				
Corporate Priority		Action	Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures	Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance
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
	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		DoS		Head of Value and Strategy	Planning, Commissioning and Strategy Group	Board
	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		DoS		Head of Value and Strategy	Planning, Commissioning and Strategy Group	Board
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%** %PCVI3 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)*	DPH	PCS DU/ Singleton DU	Lead Health Visitor	USC Service Improvement Board	P&F Committee
	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 1.1%. There are remedial actions being undertaken particularly with L3 Pharmacy referrals and insight research. ABMU continues to perform well against the WG target for co validated 4 week quits.	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= 1.1% (Aug-18)	DPH	PCS DU / NPT DU	Principal Public Health Practitioner	USC Service Improvement Board	P&F Committee
	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					Changes in the recommended vaccines for individuals aged 65 years and over and those under 65 with chronic conditions has resulted in staggered and delayed vaccine delivery which has impacted on the number of patients currently invited for their flu vaccine. This has impacted on our current uptake rates as the trajectory is slightly lower in comparison to previous seasons, as is currently being reflected across Wales. As more vaccine is delivered during November, we anticipate a recovery in uptake rates. Collaborative working between GP's and community pharmacy is being promoted to ensure patients receive the most effective vaccine.	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
	A3	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 • Demand for routine and urgent dental care services remains high despite the increased service commissioned in November 2017 and April 2018 plus additional urgent access sessions • 12,500 Units of Dental Activity (£300,000) has been commissioned from a new practice in Port Talbot but has been delayed whilst the practice awaits lifting of restrictive building covenant • High patient demand for access to urgent dental care continues, with the number of patients accessing the In Hours Access Service increasing on an annual basis: 9% from 2016 to 2017. April -Sep'18 data also shows 1% increase of usage compared with the same period in 2017. NB this figure includes repeat visits by patients who choose to access dental care through this service rather than unique individual patient numbers • Practice year-end figures for April'17- March 2018 confirmed improved performance against contracted UDA targets:compared with previous year: * 27% of practices over-performed, achieving >100% of their contracted target. * 32% of practices achieved delivered their contract within regulated tolerance level (95-100%) * 40% of practices delivered less than 95% of their contracted UDA target and monies reclaimed for the underperformance. • Contract information available in year to date indicates that the increase in UDA	Improve on 201718 baseline as measured through GDA statistics		COO	PCS DU	Head of Primary Care	USC Service Improvement Board	P&F Committee
	A5	Improve primary care screening for chronic conditions	Q1-Q4					Development of an integrated diabetes model work ongoing through Cluster networks: • North Cluster ICL CVD Risk Assessment Programme; • Pre-diabetes screening in 4 clusters. delivered within 3 practices of North Cluster to date.	Reduce variation practice to practice by Cluster Network		COO	PCS DU	IMTP Lead PCS	USC Service Improvement Board	P&F Committee
	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					Plans for Wellbeing Centres in development through Primary Care and ARCH teams	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
Stroke Service Improvement Plan Actions	A7	Implement the DOAC service	Q2					Proposal received by IBG and project manager in place	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
	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) reconvened according to new structure and first meeting planned with new membership. Subgroups to focus on key target groups throughout the life course. Public Health Team to coordinate Healthy and Active Fund (Sports Wales) local bids and assist with applications, monitoring and evaluation. Public Health Team to apply for own bid as lead applicant. PAAG meeting planned for December 2018. Actions going forward to be agreed at meeting. 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
	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. Pilot of Foodwise being delivered in Swansea Cluster. Limited Weight Management Programmes delivery across HB continues.A report is being produced following the Pilot of Foodwise delivered in Swansea Cluster.	Obesity pathway review		DPH		Head of Nutrition and Dietetics	Stroke Service Improvement Board	P&F Committee
	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		DPH		Principal Public Health Practitioner	Stroke Service Improvement Board	P&F Committee
	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.		DPH		Principal Public Health Practitioner	Stroke Service Improvement Board	P&F Committee
	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
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.	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	COO		Cancer Quality and Standards Manager	Cancer Service Improvement Board	P&F Committee

Corporate Priority		Action	Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Impact Measurement: Measure	Current position where numerical measures	Responsibility and Accountability: Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance
	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. 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		COO		Cancer Quality and Standards Manager	Infection Control Committee	Q&S Committee
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.			DPH	PCS DU	Principal Public Health Practitioner	Infection Control Committee	Q&S Committee
	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
	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
	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
	A23	Review pathways for patients with biliary tract disease (Simon Weaver - POW)	Q1								DPH	POW DU		Infection Control Committee	Q&S Committee
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	Quality Strategy approved		DoT		Head of Risk, Patient Experience	Q&S Committee	Quality and Safety Committee
		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. 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 priorities as a result. Metrics to monitor improvements in patient flow include: • The number and percentage of patients who have an EDD • Readmissions within 28 days of discharge • The percentage of patients discharged before midday.	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
	M6	**Roll out Comprehensive Geriatric Assessment**						Our plans to enhance and develop frailty models during the year within existing resources have been largely been implemented. This includes the following services: • 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
	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
		Improve outcomes following stroke						See Action No O16-O19	NHS Wales Outcomes Measures						
	M8	**Improve End of Life Care**						Ongoing actions through the End of Life Steering Group	Metrics from the Quality Dashboard (TBC)		DoT	All DUs	Head of PE, Risk and Legal Services		Q&S Committee
	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
	M10	**Reduce pressure ulcers**	Q1-4					**Hospital Acquired Pressure Ulcers** For quarter 2 the total number of pressure ulcers acquired in hospital was 153, of this 52 were graded 3+. This is an increase compared to quarter 1, which reported 144 hospital acquired pressure ulcers, of which 40 were graded as 3+. Comparing the 6 monthly figures of 2017/18 and 2018/19 the total 6 monthly figure for hospital acquired pressure ulcers in 2017/18 was 288, with 103 reported as grade 3+. For the same period in 2018/19 a total of 297 pressure ulcers were reported, 92 of which were grade 3+. These figures show a 3% increase in total hospital acquired pressure ulcers and a 10% reduction in those grade 3+. **Community Acquired Pressure Ulcers** For quarter 2 the total number of pressure ulcers acquired in the community was 227, of this 71 were graded 3+. This a slight decrease compared to quarter 1, which reported 228 community acquired pressure ulcers, of which 75 were graded as 3+. Comparing the 6 monthly figures of 2017/18 and 2018/19 the total 6 monthly figure for community acquired pressure ulcers in 2017/18 was 412, with 110 reported as grade 3+. For the same period in 2018/19 a total of 455 pressure ulcers were reported, 146 of which were grade 3+. These figures show a 10% increase in total community acquired pressure ulcers and a 33% increase in those grade 3+.	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
		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					September 2018 4 hour performance – 77.5%	NHS Wales Outcomes Measures	77.50%	COO	MDU, POW DU	Asst COO	P&F Committee	P&F Committee
	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**						September 2018 12 hour waits - 588 >1 hour ambulance waits - 526 • 8 minute response times - 78.3%		588	COO	MDU, POW DU	Asst COO	P&F Committee	P&F Committee
	M13	**The percentage of emergency responses to red calls arriving within (up to and including) 8 minutes**						Health Board Category A performance was 78% in June 2018 which exceeds the National target of 65%.		78%	COO	MDU, POW DU	Asst COO	P&F Committee	P&F Committee
	M14	**Number of ambulance handovers over one hour**						The number of >1 hour handover delays for patients arriving by ambulance has seen a month on month reduction during Q2. However performance against this measure has not achieved the internal trajectories set by the HB.		541	COO	MDU, POW DU	Asst COO	P&F Committee	P&F Committee
		Stroke Care													

Actions and timescale								Impact Measurement		Responsibility and Accountability				
Corporate Priority	Action		Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures	Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance
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%	COO	MDU, POW DU	Assoc Dir R&S	Stroke Service Improvement Board	P&F Committee
	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%	COO	MDU, POW DU	Assoc Dir R&S	Stroke Service Improvement Board	P&F Committee
	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 currently ongoing 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.		69.00%	COO	MDU, POW DU	Assoc Dir R&S	Stroke Service Improvement Board	P&F Committee
	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		11.00%	COO	MDU, POW DU	Assoc Dir R&S	Stroke Service Improvement Board	P&F Committee
	Planned Care														
	M19 **The %age of patients waiting less than 26 weeks for treatment**		Q1-4					In September 2018:- • There are 89 patients, mainly contained within Ophthalmology (58%), waiting over 26 weeks for a new outpatient appointment.	NHS Wales Outcomes Measures	89.10%	COO	All acute DUs	Asst DoS	Planned Care Service Improvement Board	P&F Committee
	M20 **The number of patients waiting more than 36 weeks for treatment**							In September 2018 • There are 3,381 patients waiting over 36 weeks for treatment. When compared to September 2017, this is an improvement of 903 over 36 week breach patients. ENT, General Surgery, Oral/ Maxillo Facial (OMF) and Orthopaedics collectively account for 3,088 of the 3,381 over 36 weeks. 97% of the patients waiting over 36 weeks are in the treatment stage of their pathway.		3,381	COO	All acute DUs	Asst DoS	Planned Care Service Improvement Board	P&F Committee
	M21 **The number of patients waiting more than 8 weeks for a specified diagnostic test**							The health board did not deliver against the profile of Nil at the end of Q2. Excluding the previously unreported suite of cardiology diagnostics, the deterioration was reported within the specialty of non-obstetric ultrasound as a result of workforce issues. Plans to outsource as an interim measure are in place to recover the position in Q3 whilst a sustainable solution is sought.		762 (123 Non Obstetric Ultrasounds, 4 Cystoscopy, 635 Cardiac tests).	COO	All acute DUs	Asst DoS	Planned Care Service Improvement Board	P&F Committee
	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 Q2 although in-month performance has slightly improved for both follow up booked and not booked. Q3 plans are expected from each of the service delivery units demonstrating improvement and to ensure that the highest risk patients are not being harmed as a result of the delay.		66,269	COO	All acute DUs	Asst DoS	Planned Care Service Improvement Board	P&F Committee
	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.	HB trajectory is 98% (WG target)	96%					
	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.	HB trajectory is 90% (WG target is 95%)	83%					
	HCAIs														
	M25 **Achievement of C.Difficile trajectory (15 % reduction on baseline 201718)**		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 Q1 17/18= 150)	DoN	All DUs	Head of Nursing, IPC	Infection Control Committee	P&F Committee & Q&S Committee
	M26 **Achievement of S. Aureus bacteraemia trajectory (10% reduction on baseline 201718)**							At the end of Quarter 2, the cumulative number of Staph. aureus bacteraemias was 101, 15 cases more than the IMTP profile, and 7% more cases compared with the same period in 2017/18.		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
	M27 **Achievement of E.coli bacteraemia trajectory (5% reduction on baseline 201718)**							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)	DoN	All DUs	Head of Nursing, IPC	Infection Control Committee	P&F Committee & Q&S Committee
	M28 **Rebalance mental health and learning disability models from inpatient to community-based models**		Q4					Investment in community resources approved from WG innovation and transformation fund. • Closure of 2 OPMH wards completed with agreement of CHC. • Strategic framework agreed by Regional Partnership Board. To be signed off by Health Board in November 2018. This sets direction for shifting focus for future services. • Early intervention in psychosis service expanded along with Perinatal Mental health Services in terms of access to therapies. • Tender for external provider to deliver psychological therapies waiting list initiative awarded and work commenced. Reduction in number of people waiting for high intensity psychological therapies indicated. Alongside this planning for redesigned pathway to improve likelihood of sustainable provision has commenced.	Measure TBC		COO	MHLD DU	Head of Planning and Partnerships	MHLD Commissioning Board	P&F Committee
	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		COO	PCS DU	Head of OOH	USC Service Improvement Board	P&F Committee
	A25 Improve access to GP care including changes to OOH services		Q1-Q4					Remote working for GPs in GPOOH has been introduced using Cisco telephony platform to enable telephone triage and advice to be undertaken with red box recording on phones. • Detailed improvement plan in place to move GPOOH to a more MDT based Urgent Primary Care Service introducing nurse practitioners, paramedics, advanced practice pharmacists, physicians associates and health care support workers into the service. • Deep dive into Adastra case notes undertaken to ascertain level of activity that can be met by alternative practitioners (other than GPs). Result of data analysis informed the development and implementation of the improvement plan. • Two Band 6 nurses from 111 Service to start with Urgent Primary Care over Winter 2018/19 seeing patients face to face as part of MSC Advanced practice pathway. • One Physicians Associate due to start placement with Urgent Primary Care June – September 2019. • 11 Pharmacist trained in minor illness, 3 assessed and ready to start seeing patients face to face in Urgent Primary Care. • Memorandum of Understanding in place with WAST for the provision of paramedics to undertake all home visits in Urgent Primary Care 20:00 – 08:00 7 nights of the week, 52 weeks of the year. Starting 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

Actions and timescale									Impact Measurement		Responsibility and Accountability				
Corporate Priority	Action		Timescale	Progress				Quarterly commentary on progress	Measure	Current position where numerical measures	Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance
				Q1	Q2	Q3	Q4								
Unscheduled Care Service Improvement Plan Actions	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
	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
	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)		COO	PCS DU	Nurse Director PCS DU	USC Service Improvement Board	P&F Committee
	A29	Review skill mix in community nursing and implement changes recommended by Cordis Bright and Capita	Q3-Q4					Actions ongoing. We are implementing a new policy to enable HCSW to aminster 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
	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 referrall to ED or admission to acute or psychiatric inpatient care	Q1-Q4					Proposals for enhancement of Care Home inreach to bring consistency to delivery in each local authority area agreed by Welsh Government. • Recruitment under way to add nurse registrants, non registrants or therapists according to identified gaps.	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
	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%.	COO		Asst COO	USC Service Improvement Board	P&F Committee
	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.		COO		Asst COO	USC Service Improvement Board	P&F Committee
	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.		COO		Asst COO	USC Service Improvement Board	P&F Committee
	A34	Implement changes to surgical unscheduled care pathways at POW within resources, eg '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.	Contribution towards achievement of HB target for 4 - hour waits.		COO	POW DU	SD, POW DU	USC Service Improvement Board	P&F Committee
	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.		COO	MHLD DU	IMTP Lead MHLD DU	USC Service Improvement Board	P&F Committee
	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.	68.80%	COO	MDU	SD, MDU	USC Service Improvement Board	P&F Committee
	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%	COO	POW DU	SD, POW DU	USC Service Improvement Board	P&F Committee
	A39	Ensure Minors streams meets 4 hour standard.	Q4					Minors performance has been affected by the majors demand in Q2. There will be an increased focus on the management of minors patients within the Emergency Department during Q3 to ensure pathways and processes are established to deliver 4hr performance sustainably.	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
	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.		COO	All hospital units	Asst COO	USC Service Improvement Board	P&F Committee
	A41	Roll out TOCALS model to Singleton and POWH	Q1					Initial mapping underway. Senior Matron Sharron Price has linked with Jason Crowl as he is mapping similar pathways regarding Discharge to Assess models	Model rolled out		COO	NPT DU	NPT SD	USC Service Improvement Board	P&F Committee
	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.		COO	MHLD DU	MHLD SD	USC Service Improvement Board	P&F Committee
	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
	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
	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

Actions and timescale									Impact Measurement		Responsibility and Accountability				
Corporate Priority	Action		Timescale	Progress				Quarterly commentary on progress	Measure	Current position where numerical measures	Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance
				Q1	Q2	Q3	Q4								
	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. 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 priorities as a result. Metrics to monitor improvements in patient flow include: • The number and percentage of patients who have an EDD • Readmissions within 28 days of discharge • The percentage of patients discharged before midday.	Strategy Developed		DoT	All hospital units	Asst DoT	USC Service Improvement Board	P&F Committee
	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 • 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.		COO/DoS		Head of IMTP Dev	USC Service Improvement Board	P&F Committee
	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 teh 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
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.		COO		Assoc Director R&S	USC Service Improvement Board	P&F Committee
	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
	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.	Access to TIA clinic within a number of days from referral (TBC)		COO		Assoc Director R&S	USC Service Improvement Board	P&F Committee
	A53	Capture patient reported outcomes through occupational therapy patient survey.	Q1-Q4					No information available	Increase in use of PROMS		DoN		Assoc Director R&S	USC Service Improvement Board	P&F Committee
	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.	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
	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 are now prioritised electronically	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
	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
	A59	Planned care programme delivery of changed pathways of care	Q1-4					Audiology, eye care and dental planned care pathwyas benig 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
	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.	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
	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.	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
	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.	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
	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
	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.	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
	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.		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee
	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.	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
	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	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
	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.	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

Actions and timescale									Impact Measurement		Responsibility and Accountability				
Corporate Priority	Action		Timescale	Progress				Quarterly commentary on progress	Measure	Current position where numerical measures	Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance
				Q1	Q2	Q3	Q4								
	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.	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
	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.		COO COO/DoF COO-DoF		Asst DoS	Planned Care Service Improvement Board	P&F Committee
	A71	Implement inpatient patient surveys in cardiac services and ophthalmology.	Q2					No information available	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.	Reduced backlog in FunB / appropriate and timely monitoring of patients.	6% increase in delayed follow-ups (Sep-18 compared with Sep-17).	COO / DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee
	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.	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
	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.	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
	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 (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.		COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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 proceduresithin 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.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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.	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
	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.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee

Actions and timescale								Impact Measurement		Responsibility and Accountability				
Corporate Priority	Action		Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures	Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance
Cancer Service Improvement Plan Actions	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.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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
	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
	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
	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
	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
	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.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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. Actions are ongoing.			COO/DoS		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	A94	Implement Non-Surgical Cancer Strategy	Q1-4					In progress (see A91)	As line 93		DoS/COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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.			DoS/MD		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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.					Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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.			COO/DoS		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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
	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
	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.	Measure patient satisfaction through Patient Satisfaction Surveys Reduced complaints Audit		COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee

Actions and timescale								Impact Measurement		Responsibility and Accountability				
Corporate Priority		Action	Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures	Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance
	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.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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 are 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.			MD		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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.	Compliance against the Cancer Information Framework. Audit outcomes.		DoNQ		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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.			MD		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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			MD		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
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.	% 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
	A115	Isolate patients with unexplained diarrhoea within 2 hours of symptom onset.	Q1					In Quarter 2, the percentage of patients that had been isolated within 2 hours of unexplained diarrhoea had improved from 44% in Quarter 1 to 50%. • 71% of patients had been isolated within 24 hours of unexplained diarrhoea. • Lack of single room availability impacts on ability to isolate.	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
	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.	% 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
	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
	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 2 average compliance: - PVC insertion bundle - 83% • PVC maintenance bundle - 79%.	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).		DPH/DoN		Lead Nurse - IPC	Infection Control Committee	Quality and Safety Committee
	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
	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.	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
	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
	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
	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					Information on urinary catheter incidence collected in pilot wards at Morriston, Princess of Wales and Singleton; this is rolling out to remaining Delivery Units using PDSA improvement methodologies. • Use of bundles monitored via Care Metric. Quarter 2 average compliance: - Urinary catheter insertion bundle - 91% • Urinary catheter maintenance bundle - 90%.	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

Actions and timescale									Impact Measurement		Responsibility and Accountability				
Corporate Priority	Action		Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures	Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance
	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)	DoN		Lead Nurse - IPC	Infection Control Committee	Quality and Safety Committee
	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
Delivery Plans	D1	Cancer Delivery Plan	Q4								DoS		Delivery Plan Management Leads	P&F Committee	Board
	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 891 beds or bed equivalents in October – preliminary findings identified opportunities for improvement across the care system • ABM have continued to benchmark LOS opportunity against English and Welsh peer groups using the CHKS tool.	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
	M30	**Theatre efficiency**	Q1-4					Actions ongoing	Achieve 90%	74% achieved at Morriston at end Q2	COO	Hospital DUs	Head of Information	P&F Committee	Board
	M31	**New Ops - DNAs**	Q1-4					Outpatient appointment text reminder service implementation - review of current arrangements underway by Information / Service Improvement team – recommendation by the end of Q3. • 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 to be undertaken by each delivery unit lead in Q3 include: • To 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	1% reduction (Sep-18= 6.1%, Sep 17= 7.1%	COO	All DUs	Service Improvement Manager, NPT	P&F Committee	Board
	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)	COO	All Dues	Service Improvement Manager, NPT	P&F Committee	Board
	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 is in final preparations for consideration by the IBG. The Document is being developed by the Project Lead with the support of the delivery unit leads. • A Status report is being prepared for consideration at the November Finance and Performance Committee – to be presented by Dr Sandra Husbands – Executive Director Lead. • Internal Audit have completed their review of progress against the WAO recommendations. Their report has been received and an action plan agreed. • 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
	M34	**Redesign Service pathways using VBHc approach**	Q4					COPD business case approved by IBG, posts recruited in September. Monitoring and data requirements being agreed. TOABC data collection completed and matched to outcome measures ready to submit to All Wales Group	N/A		MD	VBHc Team	Head of Value and Strategy	P&F Committee	Board
	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 Workstream Group • Bed Utilisation Survey undertaken on 3rd October & results will bepresented to Executive team on 28th November. • Joint Evaluation Group with partners also being established - 30th November	N/A		DoS	Service Remodelling Workstream	Head of IMTP Dev	P&F Committee	Board
Corporate Objective 4 - Securing a Fully Engaged and Skilled Workforce															
		Achievement of Workforce Indicators:													
	M36	**Reduction in vacancy rate**						• 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 3ith 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 . • 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 work will again be reported to the Finance and Performance and WOD Committees and WOD in November. • 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 degree in nursing. Seven commenced in September 2017 on a four-year programme, the remainder commenced in January 2018 on a two year nine month programme. We have also secured further external funding to offer similar places to Thirteen HCSW's in 18/19 and recruitment to these places is underway. • A further thirteen of our HCSW's are currently undertaking a two-year master's programme. • Eight HCSW's with overseas registration have recently commenced a programme developed with Swansea University to become registered nurses in the	Reduce by 5% on 2017/18 eoy baseline		DoHR		Asst DoHR	P&F Committee	Board

Actions and timescale									Impact Measurement		Responsibility and Accountability				
Corporate Priority	Action		Timescale	Progress				Quarterly commentary on progress	Measure	Current position where numerical measures	Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance
				Q1	Q2	Q3	Q4								
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).	DoHR		Asst DoHR	P&F Committee	Board
	M38	**Reduce sickness absence**						The 12 month rolling performance to the end of August 18 is 5.86% and represents an overall decline in performance of 0.09% since the beginning of 2018/19. Long term sickness rates continue to be a challenge with rates at 0.21% higher than 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	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
	M39	**Improve PADR compliance**						Reporting figures demonstrate an increase in PADR compliance of 1.71% between March 2018 and September 2018 (61.46% to 63.17%). • 8 cohorts of PADR training have been delivered covering 148 managers since April 2018.	Achieve 85% target	65%	DoHR		Asst DoHR	P&F Committee	Board
	M40	**Improve mandatory and statutory training compliance**						As of September 2018 Statutory and Mandatory Training compliance is 66.27% for the 10 UK core skills framework plus 3 local competencies. This is a 2.27% increase from August 2018. This means over 5000 competencies completed within a one month period	Achieve 85% target	65%	DoHR		Asst DoHR	P&F Committee	Board
	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. • We have engaged with Kendall Bluck via Medacs 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 with Medacs 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. • Review of data collection from agency diagnostic tool, develop plans to implement findings.	Reduce by 10% from eoy 2017/18 baseline		DoHR		Asst DoHR	P&F Committee	Board
	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. 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
	M43	**Improvement in staff engagement**	Q4					NHS Wales Staff Survey 2018 • 4,086 responses out of 15,966 – Highest response rate to date •5th July 2018 Chairman's ceremony to coincide with 70th Anniversary •225 nominations received •1,792 individuals casting a total of 9,083 votes. •11 categories •11 winners 23 highly commended £1,122.06 raised for Golau on the night Long Service Recognition •2nd year of recognition •119 staff attended the event •Total of 3,478 years' service in attendance Patient Choice Awards •51 individuals and teams recognised in May at Morriston, following 22 patients nominating NHS@70 Celebrations 70 Faces •213 staff combining of individuals and teams had their photographs taken as part of the ABMU@70 project. The aim of this project was to capture 70 images representing the diversity of the present-day roles that enable ABMU to provide the wide range of services and care, 70 years from when the NHS was established.	Staff survey (against 2017/18 baseline)		DoHR		Asst DoHR	P&F Committee	Board
USC Service Improvement Plan Actions	A126	Implement the local and Health Board wide programme of workforce redesign for Unscheduled Care.	Q1-Q4					Ongoing	Achievement of Workforce Improvement Indicators. Achievement of actions outlined above.		COO/DoHR		Asst COO	USC Service Improvement Board	P&F Committee
Stroke Service Improvement Plan Actions	A127	Explore opportunities to expand targeted 7 day cover through workforce redesign	Q1-4					Ongoing	Increase the number of generic roles.		DoHR		Assoc Dir R&S	USC Service Improvement Board	P&F Committee
	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		COO		Assoc Dir R&S	USC Service Improvement Board	P&F Committee
	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.	Evidence of staff who have received stroke training awareness sessions.		DoHR		Assoc Dir R&S	USC Service Improvement Board	P&F Committee
	A130	Continue training and awareness in communication skills and advance care planning.	Q1-Q4					In progress	Improve End of Life Care		DoT		Assoc Dir R&S	USC Service Improvement Board	P&F Committee
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					Agreement in Infection Prevention & Control Committee that there will be a summit meeting scheduled to discuss proposals relating to the resources required to achieve this standard – by 31.12 2018.	N/A		DoN	IPC Team	Head of Nursing, IPC	Infection Control Committee	Q&S Committee
	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. Awaiting appointment of new Assistant Director of Nursing for IPC in November 2018.	Business case developed.		DoN	IPC Team	Head of Nursing, IPC	Infection Control Committee	Q&S Committee
	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.	Models reviewed.		DoN	IPC Team	Head of Nursing, IPC	Infection Control Committee	Q&S Committee
	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
	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, • September 2018 audit result IV antibiotics >72 hours - 49% of antibiotic prescriptions (target ≤ 30%)	Audits to be completed.		DoN	IPC Team	Head of Nursing, IPC	Infection Control Committee	Q&S Committee
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 6 tracker indicates that most work areas are not delivering against planned profiles • Mitigating actions have been agreed to support the achievement of control total	Savings assessment		DoF	R&S Programme Board	Deputy Dir R&S		P&F Committee
	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 Mth 6 is £2.39m over the £20m control total target based on 6/12th of £20m. 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. • Plan to deliver £20m 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
	M46	**Enabling and supporting plans delivering required improvements (to achieve financial control total)**	Q1-4					Weekly monitoring dashboard. • Financial Recovery 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
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.		COO		Asst DoS	JRPDC	Board
	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
	A138	Agree models of service where workforce can be shared.	Q2					In progress	Consultants and other staff working across boundaries.		DoS/COO		Asst DoS	JRPDC	Board
	A139	Agree repatriation pathways in place for key pressured services, vascular, cardiology (unscheduled care benefits also)	Q2					In progress	Signed off pathways in place and operational		COO		Asst DoS	JRPDC	Board