Meeting Date	**30 May 2019**	**Agenda Item**	**3.6**
Report Title	**Report on the Implementation of the Annual Plan 2018/19 - Quarter 4**		
Report Author	Ffion Ansari, Head of IMTP Development and Implementation Nicola Johnson, Interim Assistant Director of Strategy		
Report Sponsor	Siân Harrop-Griffiths, Director of Strategy		
Presented by	Siân Harrop-Griffiths, Director of Strategy		
Freedom of Information	Open		
Purpose of the Report	The paper provides the Performance and Finance Committee with a report on the implementation of the Annual Plan at the end of quarter 4 2018/19. The report has been assured by the Performance and Finance Committee on May 21st 2019.		
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 1**. 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 choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☐	☒
Recommendations	Members are asked to: - • **ENDORSE** the Quarter 4 report on the implementation of the Annual Plan 2018/19 for approval by the Board; and, • **NOTE** it will be submitted to Welsh Government for assurance purposes.			

QUARTER 4 REPORT ON THE IMPLEMENTATION OF THE ANNUAL PLAN 2018/19

1. INTRODUCTION

The purpose of this paper is to provide the Committee with a report on the achievement of the previous Health Board's Corporate Objectives and actions set out within the Annual Plan 2018/19, as at the end of Quarter 4.

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. BACKGROUND

The Annual Plan implementation monitoring report for Quarter 4 is attached at **Appendix 1** for the Committee's consideration. **Appendix 1** is the detailed internal monitoring return and the narrative explanation and summary commentary is included for ease of reference in this covering paper. This report should be considered in tandem with the main Health Board performance report.

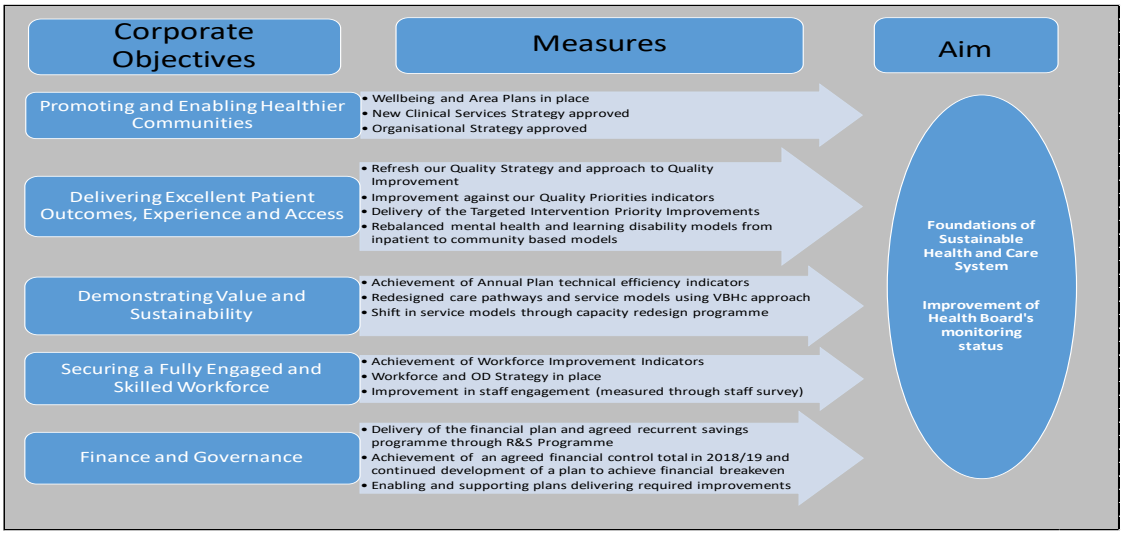
The report has been assured by the Performance and Finance Committee on May 21st 2019.

2.1 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.

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

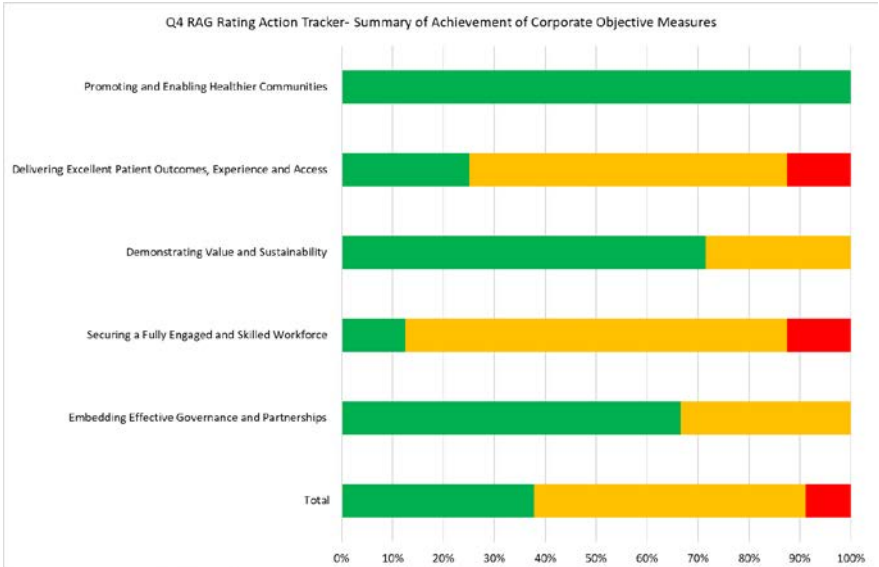
The Annual Plan 2018/19 outlined our Corporate Objectives to achieve our overall Aim of setting the foundation for future sustainability and improvement of our monitoring status. High-level measures were described to be able to monitor success in achieving the Objectives as shown in the diagram below.



The detailed monitoring report is structured to report on the previous Health Board's Corporate Objectives using colour-coded headings for each Corporate Objective as follows:

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

Performance is assessed on a Red/Amber/Green (RAG) system. The overall summary of achievement of the 45 key performance indicators against the Corporate Objectives ('M' indicators) at the end of Quarter 4 is set out in the figure below.



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

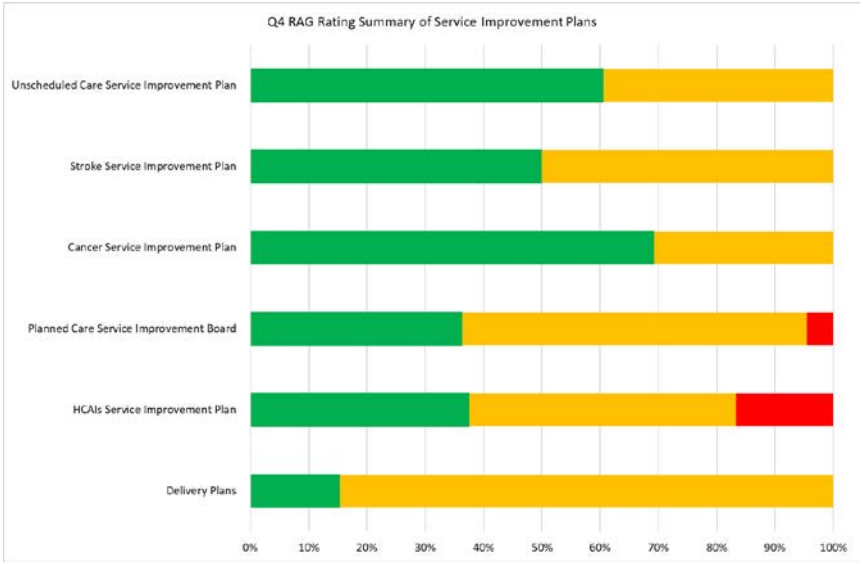
The two charts show that there is good progress with delivering our Service Improvement Plans, with very few off-track actions. The delivery of our plans is underpinning good progress in delivering our Corporate Objectives, particularly around promoting and enabling healthier communities. However at the end of Quarter 4 we were off-track with achieving a number of our key objectives for delivering improved patient access and securing a fully engaged and skilled workforce (it should be noted however that in totality this objective only has seven 'M' actions with only 3 and 1 actions 4 off track respectively).

2.1.2 Detailed Assessment of Achievement of Plans

The monitoring shows that at the end of Quarter 4 there were 93 plans which were either on-track or completed (51%) and 8 off-track plans (4%). The remainder are in progress. Delivery continues into 2019/20 for the majority of actions in the Annual Plan with activities related to continuous improvement or the delivery of longer term goals and targets. The management of these actions will continue through the performance management of the 2019/20 Annual Plan.

RAG Rating	Number of Actions	%
Red	8	4
Amber	81	45
Green	93	51
Not rated	0	0
Total	182	100

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.



2.1.3 Actions which are completed or on-track

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

Corporate Objective	On-Track or Completed Actions
Promoting and Enabling Healthier Communities	• The Board has approved its Organisational Strategy and the Clinical Services Plan was approved in January 2019. • Efforts to increase the uptake of childhood vaccinations have continued, with training in childcare pre-school settings having been delivered and immunisation promoted though the healthy schools bulletin and social media platforms. • The Health Board continues to maintain its position as provider of the highest percentage of patients receiving dental care compared to all other Health Boards and is significantly higher than the Welsh average. • Work to increase physical activity in key target groups is progressing and the early years sub-group intend to increase physical literacy and kinaesthetic play across all registered early years setting. This includes workforce development initiatives, monitoring and evaluation. The Physical Activity Alliance is also undertaking a governance review to ensure that the work of the board is sustained and reported to the respective PSB's. • We continue to improve health literacy within the population as part of a preventative approach with Making Every Contact Count (including health literacy). Train the Trainer sessions for Employee Wellbeing Champions delivered March 2019. • As part of the preparation for the implementation of the Single Cancer Pathway in April 2019, demand and capacity analysis for Endoscopy has been completed. Additional short term initiatives including insourcing, waiting list initiatives and process reviews will continue. A more sustainable capacity plan has been developed and is currently being discussed as part of the Health Board RTT delivery framework. • Work remains on track around preventing HCAIs including work on promoting the importance of hydration, reduction in antibiotic usage and catheters.
Delivering Excellent Patient Outcomes, Experience and Access	• The Health Board has implemented a range of service changes to enhance and develop frailty models during the year within existing resources including: o TOCALs service 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.

Corporate Objective	On-Track or Completed Actions
	o Implementation of the older persons assessment service (OPAS) at the front door of Morriston hospital. o The intermediate care consultants all proactively undertake CGA's. o ESD for Older People pilot started in NPT in late September - results were evaluated the results of the Early Supported Discharge pilot started in Neath Port Talbot showing that the model is effective and have undertaken further work to assess the suitability for rollout across other sites. • In our targeted intervention priority area of Unscheduled Care we: o Delivered on the 'Category A' performance for the percentage of emergency responses to red calls arriving within 8 minutes of 72.8% in March 2019 which exceeds the national target of 65%. Performance against this measure also exceeded the March 2018 response time by 6.2%. o Achieved a 7.7% reduction in the number of ambulance handovers over one hour compared with March 2018 which equates to 78 patients. o Delivered an 18% reduction in the number of patients who spend 12 hours or more in all hospital major and minor care facilities, compared to March 2018. o Delivered a 4.38% improvement in the percentage of patients who spend less than 4 hours in all major and minor emergency care facilities compared with March 2018. o Ensured that 111 is fully utilised across the Health Board. • In our targeted intervention priority area of Planned Care we: o Continued to rollout Patient Knows Best technology to embed self-management with a virtual clinic concept encouraged across other specialties. o Improved performance for New to Follow-up ratios with New DNAs reduced from 6.6% to 5.4%, Follow Ups Not Booked DNAs reduced from 8.9% to 7.0%. o A Pre-Assessment Task and Finish Group has been 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 in order to support the development and implementation of best practice solutions to improving pre-assessment arrangements. o Continued to improve the percentage of patients waiting less than 26 weeks for treatment with the

Corporate Objective	On-Track or Completed Actions
	March 2019 position of 89.32% being the highest reported position since July 2013. o Met the agreed total for the number of patients waiting more than 36 weeks for treatment. • In our targeted intervention priority area of Stroke we: o Delivered an improved position in admissions to acute beds in Morriston within 4 hours, although pressures at Princess of Wales have not improved. • In our targeted intervention priority area of HCAIs we: o Achieved a 37% reduction in C. difficile infections in Quarter 4. o Achieved a 4% reduction in E. Coli infections. o Achieved a 6% reduction in in S. bacteraemia infections, although this is short of the Health Board's 10% reduction goal. • In our targeted intervention priority area of Cancer we: o Worked to improve earlier diagnosis with the Macmillan GP Facilitator through education for GPs and Clusters. o Improved patient awareness of pathways has been through use of the leaflet 'Had a test - need another' when GPs give the 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. o Continued to work towards the goal of providing the service with a visual interface of the queues at the different component stages of the current cancer pathways. This will facilitate accurate and up-to-date information in relation to demand and activity, so that departments are able to monitor and react to in real time, so they can actively manage their systems before breaches occur. o Commenced the process of moving to one radiology system across all of our sites by developing a prototype live dashboard view that will allow the user to access current queue information for all CT, MR and Ultrasound scans for all USC, Urgent and Routine scan requests received in the Health Board. o Undertaken further scoping work to determine the feasibility of extending the scope of the Rapid Diagnostic Centre clinic to take referrals from the Acute GP Unit in Singleton and A&E departments. o Have implemented a one-stop diagnostic model for postmenopausal bleeding and pelvic masses.
Demonstrating Value and Sustainability	• In Quarter 4 we have maintained theatre efficiency in Morriston hospital at 77% with overall Health Board

Corporate Objective	On-Track or Completed Actions
	performance increasing from 72% to 81% for the same period.s • The review of current arrangements for outpatient appointment text reminder services has been completed and it has been agreed to extend the pilot for a further 12 months to assess the benefits as part of the outpatients modernisation programme. • The COPD business case was approved by IBG and posts have been recruited. The team is now in place and the working protocols have been agreed with an additional Band 7 Physio post to be advertised shortly.
Securing a Fully Engaged and Skilled Workforce	• In terms of reducing staff turnover within the first 12 months of employment, the data shows particular decreases within Additional Clinical Services and our Nursing and Midwifery staff groups, which is particularly helpful given the difficulty recruiting registered nurses. This improvement may have partly been facilitated by the Nursing and Midwifery Strategy published in 2017 which gave a greater commitment to 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 Admin & Clerical (A&C) leavers in the last quarter this is consistent with an increase in the same period last year. The Medical and Dental staff group has also seen a big increase in the last quarter which is due to rotation. We are currently looking into the options available to manage exit interviews through ESR, this will enable the Health Board to have better access to data from staff who leave the organisation. • A Workforce and OD Framework has been developed in draft and shared with the newly formed Workforce and OD Forum. The Framework supports the Health Board's operating framework and is underpinned by our organisational values.
Embedding Effective Governance and Partnerships	• The year-end financial position was a £9.879m overspend, therefore the £10m control total target was achieved. • Savings of £13.3m were delivered against a savings target of £16m. This had been forecast and mitigating actions and opportunities were identified to manage the shortfall.

3.2.2 Actions which are off-track

Detailed feedback on the summary of the 8 actions which are off-track, our improvement actions and revised milestones is shown below. The 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
Delivering Excellent Patient Outcomes, Experience and Access	Stoke Care		
	CT Scan (<1 hrs)	• The standard of CT scans within 1 hour is currently not agreed locally for all strokes - this will be reviewed with the new Health Board's radiology department with a consequent review of the approaches to delivery considered. • The current aim is to undertake a CT within 1 hour for the thrombolysis calls alone, the remaining patients are falling under the Royal College of Physicians guidance of CT in <12 hours (under which compliance is mainly achieved) but operational practice is to scan everyone ASAP and within 1 hour if possible. • Meetings are being arranged with Radiology and Stroke team to address pathway policy changes and to facilitate greater and timelier access to CT scanning provision.	Q1
	Thrombolysis door to needle <= 45 mins	• Achieving Thrombolysis door to needle time has proven difficult – actions taken since August include the additional appointment of medical middle tier posts in Morriston to improve support to the A & E department and to improve access to timely thrombolysis to ensure those eligible for thrombolysis receive the intervention in a timely way. • The Units have been reviewed as part of the all Wales thrombolysis review and recommendations from that process have been developed and actioned as appropriate • Morriston Unit has seen improvements but unscheduled care pressures continue to compromise availability. The development of the HASU Business Case which will include a dedicated 1:8 consultant rota is the preferred model to address this target in the longer term and will continue to manage performance.	Q1
	Planned Care		

Corporate Objective	Off-Track Actions	Improvement Actions	Revised Milestone
	The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date	• The number of patients waiting beyond their scheduled follow up date was 67,908 at the end of March 2019. This was the largest number in 2019. 16% of the delayed follow ups were in Ophthalmology which is subject to specific gold level support and scrutiny. • A validation team has been recruited and will commence in Q1 with a specific remit to cleanse data and to focus on specialties with the highest volumes. The outpatient modernisation group is developing an action plan to implement the 5 new proposed performance delivery requirements from the national planned care programme.	Q1
	HCAI Improvement Plan Actions		
	Baseline audit of Peripheral Venous Catheter (PVC) incidence in Delivery Units. Reinvigorate STOP campaign. Adhere to best practice guidance for insertion, maintenance and removal of PVC's.	• Information on PVC incidence collected in pilot wards at Morriston; this is rolling out to other Delivery Units using PDSA improvement methodologies. o Use of bundles monitored via Care Metric. Quarter 4 average compliance: o PVC insertion bundle - 77% o PVC maintenance bundle - 85%. • Delivery Units will ensure clinical staff adhere to the use of PVC bundles.	Q1
Securing a Fully Engaged and Skilled Workforce	Reduce sickness absence	• The 12-month rolling performance to the end of February 2019 has continued to follow the improvement achieved in January and currently stands at 5.92% (down 0.03% on January 2019). This is running above the all Wales average of 5.5%. Long-term absence in February 2019 stands at 4.50%, which is down 0.08% on January 2019. • For the first time this year, February's long-term absence performance has seen three out of the five delivery units improve their long-term position, with Singleton delivery Unit decreasing the most by 0.5% since December 2018. This reduction in long-term absence coincides with challenge sessions that are being held with Delivery Units. • Short-term absence reduced by 0.58% between February 2018 and February 2019, with an increase of 620 short-term cases, and a decrease of 2,247 FTE hours between February 2018 and February 2019. This demonstrates that early	Q1

Corporate Objective	Off-Track Actions	Improvement Actions	Revised Milestone
		intervention techniques adopted from the Health Board's best practice case study are experiencing a quicker return to work date. • Actions being taken to continue the improvement include: o Outputs of the best practice case study conducted in three areas of good sickness performance are being incorporated into each DU's attendance action plans. o Development of a pilot within the Morriston Facilities Department has commenced, implementing best practice from the above case study and re-deployment of resources to facilitate these practices. o Training sessions for managers regarding the new all-Wales Managing Attendance Policy have been extended until June 2019. o Development of a full training plan to support implementation of the new Policy. o An Occupational Health (OH) Improvement Plan is complete, with targets for reductions in waiting times approved by Executive Board. This includes increasing OH secretarial support to reduce waiting times for reports to be sent to managers; reducing the number of medical follow-up appointments to reduce waiting times for management referrals; and, using OH resource release opportunities to develop more prudent, multi-disciplinary model to ensure all health professionals work to 'top of licence.' o Continuing to deliver the Invest to Save 'Rapid Access - Staff Wellbeing Advice and Support Service' enabling early intervention for Musculoskeletal (MSk) and Mental Health, ideally within 5 days (90 referrals monthly) and expediting to MSk diagnostics and surgery when required. This model was accepted as a Bevan Exemplar 2018/19. o Implementing digital dictation software for clinicians to reduce waits for OH reports to be sent to managers. Evaluation to be completed July 2019. o 300+ Staff Wellbeing Champions are now trained to support their teams' health and wellbeing and signpost to Health Board support services, promoting a prevention/early intervention approach.	

Corporate Objective	Off-Track Actions	Improvement Actions	Revised Milestone
		o Deliver 'menopause wellbeing workshops' across four main sites during 2019. o Amendments to Swansea Bay's attendance action plan are underway to be re-submitted for sign off by W&OD committee. o The staff flu campaign resulted in 54% of frontline staff being vaccinated (8580 vaccinations administered). o Continued delivery of Mental Health awareness sessions to managers. To date 24 sessions have been delivered to 209 managers. o Continued further delivery of work-related stress risk assessment training for managers. To date 32 sessions have been delivered to 267 managers in total.	
	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.	• No further progress has been made on this action • The issue has been escalated to the Health Board's Quality and Safety Committee. Swansea Bay University Health Board Environmental Decontamination Task and Finish Group was established in Q1 of 2019/20, which will report to the Decontamination Sub-Group of the Infection Prevention and Control Committee. The remit of this Task and Finish Group will be to review and make recommendations on environmental hygiene and decontamination.	Q1
	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.	• No further progress has been made with the impact of Boundary Changes continuing to be worked through as the Boundary Change will result in a reduced budget. The Infection Prevention Control Service redesign is to be reviewed, in order to propose a service fit for the future configuration of services delivered by the new Health Board.	Q1
	Consider alternative models for antimicrobial review in relation to the Focus element of "start Smart, Then Focus", e.g. nurse/pharmacist prescribers.	• In June 2019, the Health Board will be participating in the ARK project (a 5-year research applied programme funded by National Institute for Health Research). The overarching aim of ARK is to reduce the incidence of serious infections caused by antibiotic-resistant bacteria in the future, through	Q1

Corporate Objective	Off-Track Actions	Improvement Actions	Revised Milestone
		substantially and safely reducing antibiotic use in hospitals). The ARK-hospital model is being introduced to Medicine in Moriston on June 3rd 2019.	

3. GOVERNANCE AND RISK ISSUES

The report is considered regularly on behalf of the Board by the Performance and Finance Committee, as agreed during the development of the Annual Plan for 2018/19 before consideration by the Board. The Quarter 4 report was assessed by the Performance and Finance Committee on May 21st 2019.

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.

4. FINANCIAL IMPLICATIONS

There are no direct financial implications from this paper.

5. RECOMMENDATION

Members are asked to: -

- **ENDORSE** the Quarter 4 report on the implementation of the Annual Plan 2018/19 for approval by the Board; and,
- **NOTE** it will be submitted to Welsh Government for assurance purposes.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☒
	Digitally Enabled Health and Wellbeing	☒
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☒
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒

Quality, Safety and Patient Experience

The report details the Quality, safety and Patient Experience delivery against plan for 2018/19

Financial Implications

Financial delivery against plan is included in the report and tracker.

Legal Implications (including equality and diversity assessment)

Projects and actions detailed within the Tracker are considered on their own merit through the development of the Annual Plan.

Staffing Implications

Staffing and workforce performance against plan is included in the report and tracker.

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

The Annual Plan deliver support the Health Board in its delivery of our Wellbeing Objectives

- **Long Term** – The Annual Plan sits within the broader strategic context of the Health board's long term vision
- **Prevention** – The Annual Plan includes actions to address prevention and health improvement.
- **Integration** – The Annual Plan covers the breadth of the Health Board's responsibilities and actions are cross unit.
- **Collaboration –** Actions within the Annual Plan are in many instances reliant on cross organizational delivery.
- **Involvement –** The Annual Plan was developed through engagement with partners.

Report History	N/A
Appendices	**Appendices** • Appendix 1 – detailed Annual Plan Monitoring Tracker

Corporate Priority		Action	Timescale	Actions and timescale: Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Mitigating Action for Q4 if Amber or Red	Impact Measurement: Measure	Current position where numerical measures available	Responsibility and Accountability: Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance
Corporate Objective 1 - Promoting and Enabling Healthier Communities																
Promoting and Enabling Healthier Communities Objectives Measures	M1	**Wellbeing and Area Plans in place**	Q1					The Western Bay Area Plan was agreed by the Health Board in March 2018. Public Service Board's Wellbeing Plans and Plans for ICF funding have been agreed through an inclusive process.	N/A	Plans approved		DoS	Western Bay RPB	Asst DoS	Planning, Commissioning and Strategy Group	Board
	M2	**Clinical Services Strategy Approved**	Q3					The Health Board approved the Clincal Serives Plan in January 2019.	N/A	Strategy approved		DoS		Head of Value and Strategy	Planning, Commissioning and Strategy Group	Board
	M3	**Organisational Strategy Approved**	Q3					The Health Baord approved the Organisaitonal Strategy in November 2018. Corporate Branding and launch arrangements are now in discussion.	N/A	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					Training for childcare pre school setting staff has been delivered. Immunisations have also been promoted through the healthy schools bulletin and social media platforms throughout the flu season. The primary care led catch-up highlighted data discrepancies between Primary care and Child Health. A data cleansing exercise was agreed in CHG subject to admin support for the Child Health department. An SBAR has been submitted to SIG for executive approval. Resources have also been developed to share good practice to increase influenza vaccine uptake in 2 and 3 year olds.	N/A	Achieve minimum 90% uptake for childhood immunisations as measured by quarterly COVER stats in children aged 0-5yrs, aiming for 95% To achieve WG target of 55% vaccine uptake rates for those aged 6 months to 64yrs in an at risk group To achieve 45% uptake rate of the flu vaccine in children aged 2 and 3 years in Primary Care by March 2019 Aim for 90% uptake of MMR vaccination within teenage population Improve uptake of the MenACWY vaccine within primary care	**Position as at Q3:** % 3 doses of 6n 1 by age 1= 95.6% % MenB2 by age 1= 96.3% % PCV2 by age 1= 96.4% %Rotavirus by age 1= 94.3% % MMR1 by age 2= 95.2% %PCV3 by age 2= 95.7% % MenB4 by age 2= 95.2% %Hib/MenC by age 2= 94.9% % up to date in scheduled by age 4= 88.6% % 2 doses of MMR by age 5= 91.1% % 4 in 1 by age 5= 91.5% % MMR 1 by age 16=93.4% % teenage booster by age 16= 88% %MenACWY by age 16= 88.7% *(all of the above are at Dec 2019)*	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 target for smokers attempting to quit is set at 3.2% of the population in Swansea Bay UHB. Monthly activity data to February 2019 shows that we have achieved 2.3%. The 40% WG target of CO validated 4 week quits during Q4 has been achieved for all services other than Stop Smoking Wales. Service performance has been addressed and this is now improving. The Directors of Public Health Leadership Group have agreed that working together to reduce smoking prevalence is a priority and work to address implementation of the key components of the cessation system framework have been progressed in Q4. The Health Board has supported the development of a delivery plan for the integrated cessation system. Work will now progress in 2019/20. The Readiness assessment for implementation in Swansea Bay against key components has been completed. An options paper for the management of Swansea Bay UHB smoking cessation services (hospital and SSW) has been presented to the Executive Team, with the option of the Primary Care delivery unit managing all services in line with the integration agenda having been agreed. Planning for this now in progress.	Implementation of the delivery plan for the integrated cessation system and key components of the system is to be progressed in Q1 2019/20.	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= 1.70% (Nov 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					Although we await the PHW annual flu report, our Q4 figures suggest the Health Board has achieved a similar uptake of the influenza vaccines in the over 65's group with a slight decrease in our at risk groups. Positively, we have exceeded the 55% target for the diabetics and COPD cohorts. There has been an increase of 38% in the number of vaccines administered via the community pharmacy scheme. Implementation of the Winter Immunisation plan has highlighted the breadth of collaborative work within primary care with community pharmacists HV's DN's, care home staff working alongside GP's across the Health Board.	The primary care flu planning group are reviewing the 2018/19 GP practice and cluster level flu immunisation data to identify areas of good practice and to identify areas which may benefit from support in order to improve uptake in the forthcoming season. The winter immunisation plan will be revised to reflect on lessons learnt.	Increase uptake to 55% from 45% Achieve WG target (75%) for individuals aged 65 years and over	% uptake of influenza among 65 year olds= 6802% % uptake of influenza among under 65s in risk groups= 42.9%	DPH		Immunisation Coordinator	USC Service Improvement Board	P&F Committee
	A4	Improve access to dental care	Q4					The Health Board 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 a steady +0.5% increase in the total number of patients (adults and children) who received NHS dental treatment across the Health Board from the previous March: 3% more children. 0.5% more adults.	N/A	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 continues through Cluster networksand there is engagement of 6 Clusters (Bay, City, Cwmtawe, Llwchwr, Neath and Upper Valleys). There was also practice attendance from GPs and Practice Nurses for a bespoke educational training in Jan - March. • North Cluster ICL CVD Risk Assessment Programm was delivered within 5/8 practices of North Cluster. • Pre-diabetes screening is delivered in 4 clusters, and delivered within 3 practices of the North Cluster to date.	Cluster Transformation Plans include enhanced chronic conditions management based on the Tower Hamlet approach.	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					Proposal submitted to West Glamorgan Partnership for funding of MH project management to implement Strategic Framework and resources to procure a Sanctuary model service in 2019.	Development of additional wellness centres in Swansea and Neath highlighted within planning cycle. Cluster Transformation proposals highlight the developments around social prescribing and community development which align well with Mental Health Strategy along with the development of 3rd sector services across a cluster based population	Measures TBC as part of the development of Health and Wellbeing Centres		DoS	ARCH Programme Board	Head of Service Planning - ARCH	USC Service Improvement Board	P&F Committee
Stroke Service Improvement Plan Actions	A7	Implement the DOAC service	Q2					DOAC Local Enhanced Service is commissioned from GP practices.	N/A	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					The sub-groups of the Physical Activity Alliance are developing their 1 year action plans. The early years sub-group intend to increase physical literacy and kinaesthetic play across all registered early years settings. This includes workforce development initiatives, monitoring and evaluation. The 5 -18 sub-group are currently working towards developing a social media campaign; generating a movement which highlights the value of unstructured physical activity through asking young people to share their ideas on how to move more and use the assets available in the local community. The 19 - 64 sub group are working towards developing their work plan that will focus on work place physical activity and targeting the most inactive in Swansea Bay. The 65 + group is still to meet but early work suggests that the group will aim to support physical activity and tackle isolation among older people in the community. The Physical Activity Alliance is undertaking a governance review to ensure that the work of the Alliance is sustained and reported to the respective PSB's.	N/A	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 the Foodwise Weight Management Programme by NERs and Community Groups. Support of the School Holiday Enrichment Programme working in Partnership with Local Authority Limited Weight Management Programmes delivery across the Health Board continues. Promotion of Clusters continues to take forward the Foodwise Weight Management Programme. there is continued provision of Diabetes Structured Education and provision of training to HV, 10 healthy steps Update sessions have been provided for clusters in delivery of the Pre Diabetes - Brief Intervention.	TheObesity Pathway Review commenced. The Steering and Implementation Group met in March 2019 chaired by the Director of Public Health. Currently a mapping exercise is being undertaken across the Health Board and with partners. An Obesity Pathway Delivery Review workshop is planned for May 2019.	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					Make Every Contqaact Count (MECC) (including health literacy) Train the Trainer sessiona for Employee Wellbeing Champions was delivered March 2019.	N/A	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					Make Every Contqaact Count (MECC) Train the Trainer sessiona for Employee Wellbeing Champions was delivered March 2019.	N/A	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					A Capacity and Demand analysis for Endoscopy was completed and agap of 124 points per week (inclusive of USC) was confirmed. Additional short term initiatives including insourcing, waiting list initiatives and process reviews are to continue and a more sustainable capacity plan to be developed and these are currently being discussed as part of the Health Board RTT delivery framework.	N/A	Reduce USC and NUSC referral rates.		COO		Cancer Quality and Standards Manager	Cancer Service Improvement Board	P&F Committee
	A16	Progress on tackling risk factors for cancer to be monitored and reported through the Public Health Outcomes framework by health boards and trusts.	Q1-4					See actions A1-A6				DPH				
	A17	Review ABMUHB smoking cessation services to align with National Tobacco Delivery Plan.	Q2					See action A2				DPH				
	A18	Head and Neck services to continue actively promoting Human Papilloma Virus vaccination for boys in Wales.	Q1-4					In August 2018, the Cabinet Secretary for Health and Social Services announced the extension of the HPV vaccination programme to boys in Wales The H&N MDT is actively promoting HPV vaccines for both boys and girls as part of core business. Action complete.	N/A	Reduce referral rates		COO		Cancer Quality and Standards Manager	Infection Control Committee	Q&S Committee
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. The Campaign was launched in March 2018 by Public Health Wales. The IPC Team has drafted a poster to promote increasing fluid intake using urine colour as an indication for hydration need. Once approved, a bid for Charitable funds will be made.	A progress update has been sought from the Welsh Translation Team. Following this, Procurement will secure quotations for additional Welsh posters, which should reduce the cost per poster.	% reduction in Co-Amoxiclav usage across the Health Board in 2017/18 baseline. % reduction in acid suppressant usage across Health Board on 2017/18 baseline.		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.	N/A			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.	N/A			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.	N/A			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																
Delivering Excellent Patient Outcomes, Experience and Access Objective Measures	M4	**Refresh our Quality Strategy and approach to Quality Improvement**	Q4					The Quality Strategy in now in development and will contrinute to the development of the Health Board's IMTP 2020/21-22/23	Work will continue thorughout 2019/20 with Quality being a core factor throughout the Health Baord's IMTP 2020/21.	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. • The findings from the DU complex discharge audit confirmed that there is evidence of wards where there is exemplar practice in the application of the SAFER process, however there remains variation in relation to wholesale implementation.	An improvement programme is being progressed under the leadership of the Director of Nursing and patient experience to reduce variation in the application of the SAFER flow policy within the delivery units. Progress will be monitored at quarterly performance reviews. Measures that monitor improvements in patient flow include: • The number and percentage of stranded patients • The percentage of patients discharged before midday • The number and percentage of patients who have an estimated date of discharge to inform their discharge planning arrangements. A revised Health Board patient flow policy is being completed which will reinforce SAFER) following the identification of additional resource to support the policy review and this will be the framework for ensuring patient flow and safety.	Patient Flow metrics collected via Patient Flow Dashboard		COO	All DUs	Head of PE, Risk and Legal Services	USC Service Improvement Board	Q&S Committee
	M6	**Roll out Comprehensive Geriatric Assessment**						The Health Board has implemented a range of service changes to enhance and develop frailty models during the year within existing resources. • TOCALs service into Neath Port Talbot Hospital • The full implementation of the multi disciplinary older persons service at Singleton hospital (ICOP) • Implementation of the older persons assessment service (OPAS) at the front door of Morriston hospital. • The intermediate care consultants all proactively undertake CGA's.	N/A	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**						The Quality Improvement Strategy group commences in partnership with Welsh Risk Pool in Quarter 1 2019	N/A	Reduction in number of falls on 2017/18 baseline - from Quality Dashboard	Q4 18/19= 943 compared with Q4 17/18= 1010	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**						End of Life Care reporting structures are currently under review.	Action points are to be taken from the Specialist Palliative Care Review undertaken in May 2018 in order to set the work plan for 2019 /20.	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**	Q1-4					Measures in development		1. NELA 2. National Vascular Registry Data 3. ERAS metrics	Co6taR1ca?g?	DoT	Exec Lead	Head of PE, Risk and Legal Services		Q&S Committee
	M10	**Reduce pressure ulcers**						A significant reduction was achieved in the number of serius incidents related to pressure ulcers (a 29% reduction). However, the number of incidents went up 3%.	Delivery units will be set with refining their delivery unit improvement plans in Q1.	Reduction on 2017/18 baseline through Quality Dashboard	Q4 18/19= 159 compared with Q4 17/18= 139	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 Traiectories:														
		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					March 2019: 4 hour performance – 75.81% This is a 4.38 % improvement compared with March 2018 but performance against this measure has not achieved the Health Board trajectory.	Full implementation of improvement plans were identified within the annual plan for 2019/20. Surge capacity is being sustained on all our major hospital sites in light of increased demand. Consider, respond and implement workforce report on ED staffing in Morriston. Continue recruitment to staff vacancies. Develop Easter bank holiday plans to ensure the system is as resilient as possible. Evaluate the impact of the winter pressures funding. Progress Cwmtawe cluster model.	NHS Wales Outcomes Measures	75.61%	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**						March 2019 12 hour waits - 862 This is a 18% reduction compared with March 2018 but performance against this measure has not achieved the Health Board trajectory.	Implementation of unscheduled care improvement plans is in line with the annual plan for 2019/20. We await the Welsh Government response to the Transformation Fund bid to improve system capacity to enable timely discharge of patients from hospital and continue to progress the development of models to increase community capacity and system flow, clinically led groups focussed on improved, adherence to SAFER flow principles and discharge process.		862	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**						The Health Board Category A performance was 72.8% in March 2019 which exceeds the National target of 65%. Performance against this measure also exceeded the March 2018 response time by 6.2%.	N/A		78% (Feb 2019)	COO	MDU, POW DU	Asst COO	P&F Committee	P&F Committee
	M14	**Number of ambulance handovers over one hour**						>1 hour ambulance waits in March 2019 was 928. This is a 7.7% reduction when compared with March 2018 which equates to 78 patients. However, performance against this measure has not achieved the internal trajectories set by the Health Board.	Implementation of the unscheduled care improvement plan ia within the annual plan for 2019/20. We await Welsh Government response to the Transformation Fund bid to improve system capacity to enable timely discharge of patients from hospital, whilst continuing to progress the development of models to increase community capacity and improve system flow. We are working with the National Collaborative Commissioning Unit to target reductions in the longer ambulance handover delays at Morriston.		928	COO	MDU, POW DU	Asst COO	P&F Committee	P&F Committee
		Stroke Care														
	M15	**Direct admission to Acute Stroke Unit (<4 hrs)**	Q1-4					Whilst there has been an improvement in admission to acute beds in Morriston – pressures at the Princess of Wales have not improved. The actions that we have taken to address this has included support from the NHS Wales Delivery Unit. Following the recommendations raised in their report, Task and Finish Groups have been held to address the admission, flow and discharge processes to improve their compliance against this standard. This is clearly a difficult task when faced with unscheduled care pressures but it is one which we acknowledge needs to improve and our Delivery Unit teams are working hard to improve their performance in this area. The position has improved in Morriston and the actions taken to appoint additional middle tier medical staff (albeit there remains a constant vacancy pressure to cover) to provide increased out of hours cover will assist in managing patients into appropriate beds.	The policy for the protection of acute Stroke beds need to be diligently followed and only in very rare exceptional circumstances should they be over ridden. Patients need to be followed through the pathway with transferrs arranged to rehabilitation at pace.	NHS Wales Outcomes Measures	50.60%	COO	MDU, POW DU	Assoc Dir R&S	Stroke Service Improvement Board	P&F Committee
	M16	**CT Scan (<1 hrs)**						The standard of CT scans within 1 hour is currently not agreed locally for all strokes - this will be reviewed with the new Health Board's radiology department with a consequent review of the approaches to delivery considered. 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.	A meeting is being arranged with Radiology and Stroke teams to address pathway policy changes and to facilitate greater and more timely access to CT scanning provision.		50.60%	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 assessments at the Princess of Wales Hospital, 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 patients 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 is being covered by the Medical Team there also. However, the work within the Health Board around the development of a HASU has indicated within its minimum standards that there ought to be a dedicated 1:8 Stroke rota – and this will be explored further as part of the Business Case.	Morriston has seen improvements but unscheduled care pressures will continue to potentially compromise availability. The HASU Business Case with a dedicated 1:8 consultant rota is the preferred model to address this target.		82.30%	COO	MDU, POW DU	Assoc Dir R&S	Stroke Service Improvement Board	P&F Committee
	M18	**Thrombolysis door to needle <= 45 mins**						Achieving the Thrombolysis door to needle time has proven difficult – actions taken include the additional appointment of medical middle tier posts in Morriston to improve support to the A & E department and to improve access to timely thrombolysis – those eligible for thrombolysis receive the intervention in a timely way. The Units have been reviewed as part of the all Wales thrombolysis review and recommendations from that process have been developed and actioned as appropriate	PoW have good access. Morriston Clinical Fellows will need to respond to pressure of timely access out of hours (which is where the pressure point remains).		30.00%	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**						The 2018/19 percentage continues to improve from March 2018. The March 2019 position was 89.32% which is the highest reported position since July 2013.	Further work continues to closely manage performance and drive delivery.		89.30%	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**						At the end of March 2019, there were 2,630 patients waiting over 36 weeks which was within the agreed control total of 2,664.	N/A		2,630	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**	Q1-4					At the end of March 2019, there were 437 waiting over 8 weeks for a diagnostic test. All of the patients waiting were waiting for cardiac tests which are subject to the new reporting regime from April 2018. The Health Board agreed a control total of a maximum of 450 for the year end.	N/A	NHS Wales Outcomes Measures	437	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 number of patients waiting beyond their scheduled follow up date was 67,908 at the end of March 2019. This was the largest number in 2019. 16% of the delayed follow ups were in Ophthalmology which is subject to specific gold level support and scrutiny.	A validation team has been recruited and will commence work in Q1 with a specific remit to cleanse data and to enable focus on specialties with the highest volumes. The Outpatient Modernisation Group is developing an action plan to implement the 5 new proposed performance delivery requirements from the national planned care programme.		67,908	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)**						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. In the last 2 months we have reported our NUSC compliance as:- Jan 98%; Feb 95%. Draft figures for March 19 indicate projected achievement of 93% of patients' starting treatment within 31 days. At the time of writing this report there are 9 breaches across the Health Board in March 2019.	• 8 session Consultant Clinical Oncologist post have been advertised. • Gynaecologyare to utilise theatre capacity in Hywel Dda from the end of April, this will help to reduce overall waits to surgery for both Hywel Dda and Swansea Bay UHBs. • Chemotherapy Day Unit assessment will take place on 11th and 12th April to establish if the changes to the delivery model implemented as part of previous Service Improvement projects are still working and to consider further changes to ensure maximum utilisation of chair time.	HB trajectory is 98% (WG target)	88%					

Corporate Priority		Action	Timescale	Actions and timescale: Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Mitigating Action for Q4 if Amber or Red	Impact Measurement: Measure	Current position where numerical measures available	Responsibility and Accountability: Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance
	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**	Q1-4					Cancer performance delivery remains a significant concern and risk for the Health Board.. In the last 2 months we have reported our USC compliance as:- Jan - 85%; Feb 81%. Draft figures for March 19 indicate a projected achievement of 83% of patients starting treatment within 62 days. At the time of writing this report there are 23 breaches in total across the Health Board in March 2019. Concerns remain with the Urology Pathway with the highest number of patients in backlog. • Additional clinics are being held where possible. • A review of the utilisation of RALP lists in UHW and options to increase RALP capacity are unnnderway. • Signifcant sickness at Morrisonhas resulted in long waits to PSA/prostate biopsy clinics. The Unit are now approaching agency for cover to support the diagnostic phase of the pathway. • Workforce issues continue at POWH 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. • Clinic capacity and radiology sickness is an issue at Swansea. The Health Board is working with radiology colleagues to ensure clinics are covered/backfilled and extras are in place wherever possible. • Consultant Radiographer is to join the team in March for two days a week. • Working continues across sites to ensure all theatre capacity is utilised and backfilled. • Management of services for Breast at Swansea will transfer to Singleton Hospital from the 1st April following Boundary changes. Within Gynaecological and Lower GI services: • Additional theatres have been arranged on an adhoc basis where possible to increase surgical capacity and reduce wait to treatment times. • Surgical capacity for Gynae-oncology under is review to possibly swap theatre sessions with another specialism to increase available capacity at Morriston. • Additional backfill and WLI clinics has been arranged to accommodate LGI USC referrals.	• 4th Gynae-oncology Consultant has bene appointed following interview on the 22nd March. • Head and Neck Lump pathway is to be partially implemented from late April, with full implementation in July when the new consultant commences in post – this will streamline time to diagnosis for head and neck and haematological cancers. • Detailed Radiology Demand and Capacity plan including reporting time requirements is being worked through, including introduction of a live dashboard. • There are significant waits to prostate biopsy at Morriston due to planned and unplanned sickness, the service are liaising with agency to support the service in the short term.	HB trajectory is 90% (WG target is 95%)	76%					
		HCAIs														
	M25	**Achievement of C.Difficile trajectory (15 % reduction)**	Q1-4					At the end of Quarter 4, the Health Board had achieved a 37% reduction in C. difficile infection. However, the incidence of this infection in the Health Board was the second highest in major acute Health Boards in Wales.	N/A	NHS Wales Outcomes Measures	37% reduction (Q4 18/19= 22 compared with Q4 17/18= 67)	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)**						At the end of Quarter 4, the Health Board failed to achieve its goal of a 10% reduction in Staph. aureus bacteraemia. Although, a 6% reduction was achieved, the incidence of this infection remained the highest in NHS Wales.	• Delivery Units are to progress PDSA style quality improvement activities, with a focus on invasive vascular devices, across acute sites. • Delivery Units are to extend Aseptic Non-touch Technique training, with competence assessment, to medical staff. • Delivery Units are to focus improving ANTT competence assessment compliance in those clinical areas where patients undergo frequent vascular access (e.g. Haemodialysis Unit, Chemotherapy Unit, etc.).		(Q4 18/19= 45 compared with Q4 17/18= 50)	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)**						At the end of Quarter 4, the Health Board achieved a 4% reduction in infection, thus failing to achieve its 5% infection reduction goal. The incidence of this infection in the Health Board was the highest in NHS Wales.	• Delivery Units are to progress PDSA style quality improvement activities, with a focus on urinary catheters, across acute sites. • Delivery Units are to extend Aseptic Non-touch Technique training, with competence assessment, to medical staff.		4% reduction (Q4 18/19= 102 compared with Q4 17/18= 105)	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					The Transformation programme structure wa presented to execs covering Strategic Framework for Adult MH, OPMH and LD. A Clinical Review of Community LD services was concluded adn the formal report is due. A Workshop was held with 7 local authorities, Cardiff & Vale and Cwm Taf Health Boards to initiate agreement for a shared service model between commissioners of the service provided by the MHLD DU and the development of proposals for change. Pathway work for OPMHS that transcends part 1 and 2 Mental Health Care has been developed and is due to be consulted upon by medical colleagues working in the region. The pathway includes Standard Work Tools detailing the necessary steps and standards of care for staff to consider at each stage of the pathway. This detail includes information to facilitate decision making, outcome measures to be considered, evidence based interventions that may be appropriate for the individual and carer and considerations for discharge from the service- this detail is based on current evidence, NICE guidance, and the requirements of the Mental Health Measure Wales 2010. Another more concise easily understood pathway has been developed in draft for clients and carers that is complemented by a visual representation of a Dementia Friendly Community in Swansea Bay. This is due to be consulted upon by people living with dementia in receipt of a service from the Alzheimer's Society. Ward 21 in POWH successfully transferred to Angelton clinic with the empty space released to POWH. Progress continues with the reduction of people waiting for psychological therapies and as of the end of March19 there were no people	A proposal for transformation programme infrastructure resources was presented to Western Bay. This is for a Programme Manager to oversee and 4 project managers to support transformation programmes for OPMHS, AMH and LD. the proposal broadly were supported and are being progressed with modifications.	Measure TBC		COO	MHLD DU	Head of Planning and Partnerships	MHLD Commissioning Board	P&F Committee
Unscheduled Care Service Improvement Plan Actions	A24	Maximise use of 111 model	Q1-Q4					111 is fully utilised across ABMU Health Board.	N/A	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					There has been an expansion of Remote working GPs to 37 (including GPs working on regional basis covering the Clinical Support Hub in 111). A move to HVS in Morriston to enable development of Roundhouse model has been agreed, a target date for move set for middle of February 2019. 1 x Band 6 Nurse from 111 started to undertake sessions (7 hours per week) in Urgent Primary Care (UPC being is used as descriptor of service instead of GPOOH to represent new multi-disciplinary make up of the service) as part of Foundation course for MSc. Honorary contract is being established for a second Band 6 Nurse to start in Urgent Primary Care. Agreement has been reached with 111 to explore the potential to rotate 111 Band 6 Nurses undertaking telephone triage to also undertake face to face appointments in Urgent Primary Care. Paramedics are undertaking all evening and overnight home visits in Urgent Primary Care under a Service Level Agreement with WAST established 5th November 2018.	Work will continue to take forward draft JD for Nurse Facilitator role and pursue recruitment.	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
	A26	Increase access to pharmacy-led care, maximising the use of the new Pharmacy contract	Q1-Q4					100% of community pharmacies across ABMU were 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 £650 • 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)	N/A	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 Health Board's Winter Plan for 2018/19. The Health Baord 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.	N/A	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					Anticipatory care has been mainstreamed into core services.	ACP is now embedded into community nursing 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					The Health Board is implementing a new policy to enable HCSWs to administer medicine and is scoping the development of a band 4 HCSW role.	DP principles have ben applied. New Band 4 roles are in place in the community. On going work around revised JD is continuing	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 referral to ED or admission to acute or psychiatric inpatient care	Q1-Q4					Care Home in reach teams are operational in each Local Authority area. Manual returns of activity has been collected. A plan has been developed for inclusion of services on the clinical portal for electronic performance monitoring.	N/A	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 Health Board continues to be implemented focussing on a reduction in HCP calls. • There has been a 5% reduction in the number of ambulance conveyances to hospital when comparing 2017/18 with 2018/19. This equates to just over 2000 fewer conveyances..	The falls response vehicle introduced over the winter months is being maintained in the new financial year in Swansea Bay UHB as this is one of the big 5 conditions and is having a positive impact on reducing patient conveyance to hospital .	Reduce conveyances to hospital for non-acute the 'Big 5' conditions against the 2017/18 baseline.		COO		Asst COO	USC Service Improvement Board	P&F Committee
	A32	Implement revised falls pathway across the Health Board	Q1-Q4					Refresher training of care home staff on the i-Stumble version 1 tool across the 3 local authorities to improve the management of patients who have fallen but who have not incurred any physical injury has taken place. • I stumble version 2 has 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 started with one home in NPT and will be rolled out to the remaining homes Using this tool will support a reduction in the risk of pressure damage for 'long lie' residents awaiting a lower acuity ambulance response. WAST has also commissioned 2 falls response vehicles in the Health Board as part of the winter plan to reduce un-necessary conveyance of falls patients to hospital by an emergency ambulance	N/A	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					Provision of ambulatory care services within existing resources is ongoing, including : •The medical day unit hours at Singleton. • Review of 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	Further development of hot clinics is being planned in Q1 at Morriston hospital. A DU review of current ambulatory care services commences at the end of April 19.	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, e.g. 'chole quick', ENT pathways, trauma and gynaecology pathways.	Q1					Ambulatory Emergency Surgery -A second test of changewas delivered for six weeks from 4th June 2018 resulting in a 42% reduction in Emergency General Surgery admissions and an improvement in 4hr performance ranging between 2.63% and 5.39% daily. • A surgical ambulatory emergency care unit was piloted in Q2 and able to demonstrate a positive improvement.	No further action can be taken as this requires capital and revenue funding to progress. Schemes are being considered by Cwm Taf Health Board for 2019-20 as part of IMTP process.	Contribution towards achievement of HB target for 4 - hour waits.		COO	POW DU	SD, POW DU	USC Service Improvement Board	P&F Committee
	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 has been implemented. • Resources have been allocated to extend hours of services operation at weekends and posts recruited to. However maternity leave for existing staff members has had an impact on capacity as posts were not backfilled. Also recruitment to vacancies following post holders leaving is underway. • Proceeding with Staff consultation regarding extension of service at weekends and bank holidays. This delayed start date which is now forecast for July at the earliest.	Undertaking staff consultation for OCP regarding hours extension beyond existing 10pm.	98% compliance with 1 hour response time from referral to assessment for psychiatric liaison services. Reduction in numbers of frequent mental health attenders on 2017/18 baseline.	ED Response within 1 hour 76% and within 4 hours 91%	COO	MHLD DU	IMTP Lead MHLD DU	USC Service Improvement Board	P&F Committee
	A36	Improve advance care planning for individuals who have advanced, progressive life limiting illness.	Q1					Macmillan-funded Advance Care Planning team is 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.	N/A	Contribution to achievement of HB target for 4 hour waits on site.	68.00%	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.	N/A	Contribution to achievement of HB target for 4 hour waits on site.		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. Minors stream vulnerability in evening/overnight and during significant crowding within the ED.	Additional ENP cover during late afternoons and evenings at POW ED funded through winter pressures funding to minimise minors breaches during this time.	100% of patients categorised as Minors to be managed within 4 hours.		COO	MDU / POW DU	SD POW / SD MDU	USC Service Improvement Board	P&F Committee
	A40	Consistently implement SAFER flow bundle on all wards as a Quality Priority.	Q1					•The implementation and roll out of the SAFER flow principles remains a key element of our USC improvement plan and is overseen by the USC delivery board. • The findings from the DU complex discharge audit confirmed that there is evidence of wards where there is exemplar practice in the application of the SAFER process, however there remains variation in relation to wholesale implementation.	Compliance with SAFER flow bundles remains a priority for the organisation Delivery unit progress will be monitored at quarterly performance reviews. Measures that monitor improvements in patient flow include: The number and percentage of stranded patients • The percentage of patients discharged before midday • The number and percentage of patients who have an estimated date of discharge to inform their discharge planning arrangements. A revised Health Board patient flow policy will be completed in Q1 quarter which will reinforce SAFER as the framework for ensuring patient flow and safety.	35% of patients discharged home before lunch. 100% of inpatients have an estimated Date of Discharge. Compliance with other metrics measured through the Patient Flow Work stream.		COO	All hospital units	Asst COO	USC Service Improvement Board	P&F Committee
	A41	Roll out TOCALS model to Singleton and POWH	Q1					Initial mapping is underway. A Project is being taken forward between NPT Unit and PC&CS units to map pathways regarding Discharge to Assess models	A Project is being taken forward between NPT Unit and PC&CS units to map 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.	N/A	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 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.	N/A	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.	DTOC standard measures agreed, DTOC rates improving, new improvement team in place	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 is underway regarding contracting a revised model of domiciliary services. Working continues with NPT around supporting rapid access domiciliary services.	Rapids is in place, but overall capacity based on funding can still limit discharges. NPT is undertaking a full review of their service model. There is not improved management response for the escalation of discharge concerns	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
	A46	Develop Health Board - wide deconditioning strategy - linked to SAFER flow bundle as a Quality Priority.	Q3					•The implementation and roll out of the SAFER flow principles remains a key element of our USC improvement plan and is overseen by the USC delivery board. • The findings from the DU complex discharge audit confirmed that there is evidence of wards where there is exemplar practice in the application of the SAFER process, however there remains variation in relation to wholesale implementation.	Compliance with SAFER flow bundles remains a priority for the organisation Delivery unit progress will be monitored at quarterly performance reviews. Measures that monitor improvements in patient flow include: The number and percentage of stranded patients • The percentage of patients discharged before midday • The number and percentage of patients who have an estimated date of discharge to inform their discharge planning arrangements. A revised Health Board patient flow policy will be completed in Q1 quarter which will reinforce SAFER as the framework for ensuring patient flow and safety.	Strategy Developed		DoT	All hospital units	Asst DoT	USC Service Improvement Board	P&F Committee
	A47	Develop early supported discharge rehabilitation model	Q2					ESD for COPD was supported by IBG and is being rolled out. ESD for stroke is being developed as a joint proposal between Morriston and Singleton units. Discharge to Assess model are also in development. AnESD for Older People pilot started in NPT in late September - results were evaluated in December showing the model's effective and further workis to be done to assess suitability to rollout for other sites.	N/A	Model developed		COO/DoS	All hospital units	Asst DoT	USC Service Improvement Board	P&F Committee
	A48	Implement Service Remodelling programme in acute hospitals	Q2					• Frailty at the Front Door models developed on all three main hospital sites • ESD for COPD being rolled out across the Health Board • Innovative enabling ward in place at NPTH • Continuing focus on SAFER flow bundle • Improvements in rehab pathways and pull through to community hospitals • Public engagement undertaken on Tranche 1 and Board decision made to proceed with additional bed closure on a phased basis • 106 adult non-mental health beds (acute and community hospitals) beds closed over the last 18 months • Monthly evaluation of system impacts through Service Remodelling Work stream Group • Joint Evaluation Group with partners established - first meeting 30th November • Bed Utilisation Survey undertaken on 3rd October - results will be presented to Executive Team on 28th November. 168 beds closed over the 18month period of the project. Closure report completed and signed off by Recovery and Sustainability Board in February 2019. Joint evaluation group will continue to meet to evaluate the effect of the service remodelling.	Project formally closed.	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 the Clinical services Plan on future role and rehabilitation models.	Improvement plan now implemented with GH which has improved patient flow supporting transfers and discharges from Moriston hospital	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.	WHSCC commissioned Service planned to be in place from the 1st April 2019.	Pathway in place.		COO		Assoc Director R&S	USC Service Improvement Board	P&F Committee
	A51	Promote FAST in the identification of strokes	Q1-Q4					Continuing to support National work / communications.	Ongoing	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.	Service Director discussions to be completed on where best to provide the NPT service.	Access to TIA clinic within a number of days from referral (TBC)		COO		Assoc Director R&S	USC Service Improvement Board	P&F Committee
	A53	Capture patient reported outcomes through occupational therapy patient survey.	Q1-Q4							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							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 was by IBG and is being rolled out. ESD for stroke is being developed as a joint proposal between Morriston and Singleton units. Discharge to Assess model is also in development. ESD for Older People pilot started in NPT in late September - results were evaluated in December showing the mode is effective and further work is to be done to assess suitability to rollout for other sites.	N/A	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	N/A	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
	A57	Roll out and develop use of E-Referrals.	Q1-Q4					76% of electronic referrals were also prioritised electronically during Q4. Two specialties remain outstanding: Burns & Plastics and Cardiology (West). B&P are constrained by Cardiology (West).	We continue to work with Cardiology (West) to implement primary-to-secondary e-referrals prior to piloting hospital-to-hospital e-referrals. B&P also require the ability to send inter- and intra-hospital referrals which will be implemented following Cardiology (West).	All referrals submitted through e-referral route.		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 have been developed in accordance with the Annual Plan and Commissioning Intentions for the IMTP for 2019-22	Frailty, diabetes and COPD pathways have been 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 pathways have been developed in accordance with the Annual Plan and Commissioning Intentions for the IMTP 2019-22	Audiology, eye care and dental planned care pathways have been 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 have been delayed.	National programmes have been 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					Patient Knows Best technology is being rolled out to embed self-management. Virtual clinic concept is encouraged across other specialties.	NWIS PROMs is now working within Orthopaedics and PKB is being piloted in Urology. Shared experiences of new ways of working are being discussed in the Outpatient Modernisation group.	Virtual clinics already developed in planned care programme activities - share knowledge and develop approaches for increased use in other specialities across the Health Board where appropriate.		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee
	A62	Develop non-medical solutions for patient review - extended workforce skills for Nursing and other professionals	Q1-4					Work has been undertaken in Optometry, Audiology, and in a number of nurse led services across a range of specialties.	Extended models are being rolled out - i.e. extended ODTC plans into Primary care	Continue with Audiology / Optometry / Therapies / Dentistry and extended Nurse Practitioners across range of services.		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee

Corporate Priority	Action		Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Mitigating Action for Q4 if Amber or Red	Impact Measurement: Measure	Current position where numerical measures available	Responsibility and Accountability: Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance
Planned Care Service Improvement Plan Actions	A63	Review New to Follow-up ratios	Q1-4					• New – DNAs reduced from 6.60% to 5.40%. • FUP – DNAs reduced from 8.90% to 7.00%. • 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. .	N/A	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 are to implement clinical office sessions in job plans for key clinicians as part of the Virtual clinic developments and impact.	Job Planning is with the Delivery Units to address.	Greater throughput and active monitoring rather than face to face contacts		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee
	A65	Develop Theatre Efficiency Board role in improving performance across sites.	Q1-4					Theatre Efficiency Board has been set up with Terms of Reference and a Multi Disciplinary forum. • Local Delivery Units also have theatre committees to take forward local actions. • Information and performance measures are being reviewed.	Theatre Board arrangements are under review with a greater focus on performance improvement.	Challenging Performance and building best evidence base line performance measures.		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee
	A66	Develop and implement best practice agreed solutions to improving pre assessment arrangements.	Q3					A Pre Assessment Task and Finish Group has been set up and has made recommendations which are now being taken forward in discussion with the Morriston Delivery Unit. Clinical guidelines have also been identified and are being consulted on.	Pre Assessment changes have been implemented with a more centralised and coordinated approach to systems and pathways. New arrangements are to be monitored.	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	Work is on going and changes to monitoring being planned as part of the performance focus changes mentioned above.	Look to introduce IT to improve selection / planning and communication between departments and theatre lists.		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee
	A68	Review areas where new equipment / technology could shift activity to Day Case or Outpatient procedure / other hospitals within ABMUHB not compromised for beds.	Q1-4					Solutions are being progressed in areas such as plastic surgery and orthopaedic hands to move day case activity out of theatres and into outpatient treatment sessions where it is clinically appropriate and evidence based. Approval has been given to develop a dedicated Plastic Surgery Day case Unit in Morriston Hospital. Further design work is required in one location.	The work is due to be partially commissioned towards the end of June with the remainder commissioned in August.	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
	A69	Work with partner Health Boards to identify regional solutions to deliver routine elective surgery in protected capacity.	Q1-4					Through regional planning both Health Boards have agreed that pursuing additional bespoke capacity is not required for 2018/19 and 2019/20. Hywel Dda achieved a nil 36 week wait position for orthopaedics and the Health Baord performed better than profile for orthopaedics 930 against a plan of 1,048.	N/A	Fewer cancelled procedures. Timely access and reduced RTT waiting times pressures.	Number procedures postponed on the day opt the day before for specified non-clinical reasons 3,344	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					The Health Board achieved its agreed position on long waits. A modest number of OPs were over 26 weeks at the end of March 2019 (207). Therapy and diagnostic targets were also delivered. D&C plans were agreed and modified through the year to respond to variations from plan and ensure target delivery	N/A	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							Surveys in place		DoN		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee
	A72	Ensure that roll of F/U Priority Actions from planned care are sustainable.	Q1-4					• Sustainability plans have been agreed in Ophthalmology. • Urology is implementing PKB – self managed care – the service already has 1200+ virtual patients. • ENT discharging is meeting agreed guidelines – clinical exception is currently being reviewed. • Orthopaedic PROMs for hips and knees is in the process of being implemented once the NWIS software is released.	Implementation of Planned care changes are underway. PKB roll out to be completed by May 19, Orthopaedic PROM (pre and post Surgical) are in place. ENT guidelines are being monitored with clinical re evaluation being undertaken at a National Level for one sub specialty area.	Reduced backlog in FunB / appropriate and timely monitoring of patients.	(66.271 Mar-18 compared with 67,908 Mar 19).	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 is already underway with efforts to agree rollout into other areas such as Rheumatology. Outpatient Modernisation Group / National group is developign a greater focus on the area and have a revised plan to address in 2019 / 20.	Practices are being shared within Outpatient Modernisation Board. Delivery units are to implement. Validation team is funded and in the process of appointment to improve quality of reporting, address duplications etc.	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 is being implemented - currently pre and post operative PROMs in place.	NWIS PROMs implemented in two of the five phases. NWIS to continue to develop system.	Continue roll out of PROM's systems. Support NWIS developments and identify alternative options such as in Ophthalmology.		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee
	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					The Health Baord's Macmillan GP Facilitator has been doing work to improve earlier diagnosis. This has been mainly educational for GPs and includes lectures at the Protected Time for Learning for the clusters as well as lunch-time clinical sessions. We have been highlighting the latest evidence with regard to thrombocytosis as a possible cancer marker and making GPs aware of the ABMU CXR direct to CT pathway. Improved patient awareness of the pathway has been through use of the leaflet 'Had a test- need another' when GPs give the CXR request form to patients. Collaborative working with the radiology Department has meant that the same information is now given when patients arrive at x-ray reception through laminated information sheets and posters. Ongoing	N/A	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 procedures within those units. • A prototype live queue dashboard has been developed and verified. We are in the process of working with Informatics colleagues to activate the live version in due course. The Cancer Information and Improvement team have continued to work towards their goal of providing the service with a visual interface of the queue's at the different component stages of the current cancer pathways. It is the belief of the team that Service Groups should have accurate and up-to-date information in relation to demand and activity, that they are able to monitor and react to in real time, so they can actively manage their systems before the breaches occur. A full capacity review has been undertaken of the following parts of the pathway: Demand & Capacity Modelling First OPA: Phase one was to create a suite of 'live dashboards' by which we can monitor our weekly Urgent Suspected Cancer (USC): • Referrals (demand) • Activity (number of USC patients seen at their first clinic appointment) • Waiting list (the cumulative difference between our USC demand and activity i.e. work-in-progress) • Lead-times (time from referral to first seen in clinic) • Predict future lead times (referral received to patient first seen) Currently completed live views exist for: Breast, Colorectal, Urology, Gastroenterology, Gynae Oncology, Lung, OMF and Post-Menopausal Bleed (PMB). In addition to this, prototype views have been developed for ENT, Dermatology, Haematology and Thoracic patients. These are yet to be built in the live environment by Informatics and this will happen in due course.	N/A			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					Ongoing work. As above for endoscopy and pathology • The Health board is in the process of moving to one radiology system across all of its sites. The East of the HB (Princess of Wales and Neath Port Talbot hospitals) has been using this system for some time. The west of the HB will be moving to the new Radis system on the 24th of November. • In preparation for this the Cancer Information and Improvement team has developed a prototype live dashboard view that will allow the user to access current queue information for all CT,MR and USS scans for all USC, Urgent and Routine scan requests received in the Health Board. • The prototype dashboard and accompanying stock and flow models have already been built and are currently entering the verification phase of testing ahead of a live click view dashboard being made available. The dashboard will allow users to actively manage queue length and the outputs from the dashboard will be used to power models of the system which will allow us to ensure we have enough capacity available to complete the diagnostic phase of the new single cancer pathway. As above. The HB have submitted demand and capacity information to the NHS Delivery Unit using an analysis tool developed by the NHS DU. It was noted at a Single Cancer Pathway meeting on the 17th October 2018 that all HB's had difficulty in extracting the required information from systems at the detail required, particularly in relation to cancer investigations as there is no consistent flag across all clinical systems to identify cancer from urgent or routine work. The Cancer Information team have been working closely with radiology and Informatics colleagues to identify point of suspicion flags within the recently introduced Radis II and In-touch outpatient systems. ABMU HB have detailed D&C information in the form of live queue dashboards in a number of key high volume areas such as diagnostic radiology, endoscopy, first OPA and radiotherapy. The radiology view is the most recent of these to be developed. The live version turn on is planned for the end of February 2019. Similar work streams are planned for pathology and SACT administered via the CDU in due course.	N/A			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					Further scoping work is currently being undertaken to determine the feasibility of extending the scope of the clinic to take referrals from AGPU in Singleton and A&E departments. The Senior Team are also in discussions with Executive colleagues with regard to the future direction of the clinic. Patients referred to the service Total number of referrals received for Q4 – 141 Number of referrals rejected – 26 Total number of referrals accepted – 115 Total number of patients seen between January and March – 109 Comments: The above total number of referrals does not include the number of referrals returned to GP's due to the referral being categorised as USC as when the referrals were resent they were accepted, this eliminated the possibility of patients being counted twice. 3 referral were accepted but were not seen as the patient's declined the appointment or the RDC requirements have highlighted a site specific pathway. 8 referrals were received in December and were seen in January. 10 referrals were received in March and were seen in April. Patient outcome During January and March 2019, we have had :- Cancer diagnosis: 13 patient that has been identified with cancer. • 1x Lung – T2bN2M1c, Stage 4 • 3x Liver – All late stage • 1x Colorectal – T3N0M0 • 1x Pancreatic – Late stage • 3x Renal cell – Early stage for monitoring • 1x Cervical – Stage 4 • 2x Lymphoma – unknown stage • 1x Bile Duct Tumour – Late stage Update – 10 patients are being monitored as they have been referred for a consultants' opinion/further investigations which are	N/A	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 the prediction of 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. • Backlog has increased through March, a number of issues have contributed to this, including diagnostic waits in Urology. Reduced theatre capacity in March due to theatre staffing (leave and sickness).	New first outpatient OMFS pathway stage agreed and taken forward with Primary Care with a plan to commence in April. • New neck lump pathway agreed with a plan to implement at the end of January. • Cancer Improvement Team have developed Demand & Capacity analysis for first outpatient appointment across most specialties managing suspected cancer referrals; these will be developed into live dashboard views by Informatics with timeframes for this development to be determined • Planned pathway changes and increased capacity will also help reduce the backlog, which is being monitored very closely within the Units OMFS – First appointment issues: Streamlined pathway has been agreed by Karl Bishop, Unit Dental Director for Primary Care and Sankar Ananth, Clinical Lead OMFS, which were discussed/approved by OMFS colleagues. A meeting went ahead on 13/03 with corporate planning to discuss pathways/criteria and due to queries concerning the triage in Primary Care there is a revised start date of 1st June 2019, which has been agreed by all parties. A Pathway review has been undertaken for neck lumps with the potential for fine needle aspiration requested before first outpatient appointment. The Neck Lump Pathway has been discussed with the Clinical Director/Clinical Lead for ENT. The initial plan is to set up a standalone USC Neck Lump Clinic, which will include a diagnostic for patients fulfilling a set criteria. The plan to commence a Neck Lump USC Clinic (high risk neck lumps to be identified via WPRS vetted by H&N Cancer Surgeons). This clinic will consist of a Consultant consultation +/- USS FNA/Core Biopsy if required. As this will exclude the wait for a diagnostic appointment following first outpatient appointment, it is anticipated the streamlined pathway will reduce the overall pathway by ten days. This has been discussed and signed off by the Consultant team and the CD. A costing exercise has been undertaken and equipment reviewed. A meeting took place on 07/03 with an agreed partial implantation late April and full implementation in July when the new Consultant Commences.			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. • Clinic capacity and radiology sickness at Swansea. Working with radiology colleagues to ensure clinics are covered/backfilled and extras in place wherever possible. • Consultant Radiographer joined the team in March for two days a week. • Working across sites to ensure all theatre capacity is utilised and backfilled. • Management of services for Breast at Swansea transferred to Singleton Hospital from the 1st April following Boundary changes.	N/A			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					Management of services for Urology at PoW transferred to Cwm Taf from the 1st April following Boundary changes. Demand and Capacity modelling work has been undertaken for Urology Outpatients and available to use via the Cancer Dashboard • Clinical gaps being worked through using locum agencies as much as possible. • Concerns remain with the Urology Pathway with the highest number of patients in backlog. • Significant sickness at Morriston resulting notably in long waits to PSA/prostate biopsy clinics. The Unit are now approaching agency for cover to support the diagnostic phase of the pathway. • Workforce issues continue at POWH	. Review of the utilisation of RALP lists in UHW and options to increase RALP capacity. • Significant sickness at Morriston resulting notably in long waits to PSA/prostate biopsy clinics. The Unit are now approaching agency for cover to support the diagnostic phase of the pathway. . Additional clinics being held where possible			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.• PMB One-stop clinic commenced 5th November. Current waiting list for PMB is short and capacity converted to outpatient hysteroscopy to reduce waits for patients following the previous clinic model.• Additional clinics arranged on ad hoc basis to help reduce USC waiting times. New clinic timetable implemented alongside one-stop PMB clinics from Nov18 to increase capacity. • Revised process for Swansea vulval USC referrals. Increased capacity in RAC.• 4th Gynae-oncology Consultant has been appointed following interview on the 22nd March 2019. They will initially commence post as a locum, joining the team as a fully appointed member of staff later in the year. • Agreement to start a weekly Friday operating list for Gynaecology at Hywel Dda from mid to late April. This would be a long-term ongoing arrangement with the successful appointment of the 4th consultant. This will help reduce the waiting list of patients needing surgery at Morriston and improve waiting times for both organisations.	N/A			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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. Action completed	N/A			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	A85	MyoSure activity to be introduced to Singleton and Neath	Q3					A One-stop diagnostic model for postmenopausal bleeding and pelvic masses has been implemented. Action completed	N/A			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					The Cancer Improvement Board has been established and Terms of Reference agreed. Performance is a continuous agenda item. Meetings are held on a monthly basis.	N/A			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.	N/A			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. Cancer Performance issues are reviewed and discussed at the monthly Cancer Improvement Board.	N/A			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. Thyroid Cancer Services in Wales were peer reviewed in December 2018, no immediate risks have been reported for Swansea Bay University Health Board and an action plan is currently being developed to address the areas of concern raised. Teenagers and Young Adults with Cancer Services are currently in the self assessment stage of the Peer Review process, with a visit planned for July 3rd 2019.	N/A			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 was implemented in January 2018. Revised MDT Co-ordinator job description was implemented at POW. Implementation at Singleton remains incomplete. New MDT Co-ordinator job description implemented across HB. Action completed	N/A			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 the Helath Board, Hywel Dda University Health Board and Swansea University. This looks at the entity of the cancer pathway, in partnership with Public Health and Primary Care. The ARCH partners are working to improve the health, wealth and wellbeing of South West Wales by delivering better health, skills and economic outcomes for the people of this region. The Non – Surgical Cancer Strategy for South West Wales is one of the first projects to be developed through the ARCH partnership. The strategy focuses on delivering excellent care, improved outcomes and supporting those living with and beyond cancer. The strategy is aligned to The Cancer Delivery Plan for Wales (2016 – 2020) and its vision is "to provide the best possible care for the people of South West Wales" To help to deliver the aims and vision of the strategy, the following objectives have been agreed:- • Develop sustainable regional workforce • Develop local services linked to the specialist cancer centre • Embed a regional culture of research and innovation • Maximise digital solutions.	ARCH Strategy has been included in the Corporate Cancer IMTP to ensure focus is maintained.			COO/DoS		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
Cancer Service Improvement Plan Actions	A92	Clear plans to deliver compliance with the single suspected cancer pathway by April 2019.	Q4					No formal announcement has been made by the Cabinet Secretary yet, however the Wales Cancer Network and colleagues from Welsh Government are meeting on the 25th October 2018 and an announcement expected in November confirming a move from shadow reporting to dual reporting of both the SCP and current USC and NUSC targets in 2019. The Health Board 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. The Health Board is currently in the process of developing bids in respect of Welsh Government's allocation of funding to support the Single Cancer Pathway (SCP). Funding bids are to be submitted to the Wales Cancer Network by the 26th April 2019.	In November 2018, the Cabinet Secretary formally announced the introduction of the SCP, with Wales publically reporting from June 2019. £3 million investment has been allocated from April 2019 as part of the NHS budget settlement to support the introduction of the new pathway and to support performance and quality improvements in the pathways of care. It is expected that there will be local focus on diagnostic capacity, efficiency and investment to improve performance. One of the key priority areas to improve outcomes, reduce variation and support the implementation of the SCP is the development of common pathways across the NHS for specific cancer disease groups. 8 optimal pathways for a number of high volume tumour groups have been developed by the All Wales CSG's and circulated to our Cancer Multi-disciplinary Teams. Work has commenced with Lung and Colorectal to map and compare pathways against the optimal pathways to understand variance and consider improvements required at the various steps. This work will continue with the other tumour site groups. 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.			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. The Project Manager left this post at the end of 2018. The Health Board Cancer Executive Lead, Cancer Lead Clinician and Cancer Quality & Standards Manager met with the Project Manager on 8th June 2018 and are awaiting further correspondence.	Awaiting correspondence from WCN.	As line 93		COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee

Corporate Priority		Action	Timescale	Progress Q1	Progress Q2	Progress Q3	Progress Q4	Quarterly commentary on progress	Mitigating Action for Q4 if Amber or Red	Impact Measurement: Measure	Impact Measurement: Current position where numerical measures available	Exec Lead	Responsibility and Accountability: Delivery lead - mechanism	Responsibility and Accountability: Monitoring lead	Responsibility and Accountability: Reporting and monitoring	Responsibility and Accountability: Board Governance
	A94	Implement Non-Surgical Cancer Strategy	Q1-4					In progress (see A91)				DoS/COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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. The Helath Board 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. Thyroid Cancer Services in Wales were peer reviewed in December 2018, no immediate risks have been reported for the Health Board and an action plan is currently being developed to address the areas of concern raised. Teenagers and Young Adults with Cancer Services are currently in the self assessment stage of the Peer Review process, with a visit planned for July 3rd 2019.	N/A			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 was initiated in Morriston Lung Clinic. No progress has been made with follow up collection. No progress has been made with extending this to Singleton or NPT yet.	Discussion are ongoing with the National Clinical Lead regarding support to consider expansion options. Links made with HDUHB re takign place reagrding the sharing of learning.			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 have been reviewed and monitored via the Cancer Improvement Board. • Outstanding actions have been reviewed at the 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.	N/A			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 are only possible at Singleton Delivery Unit when there are suitable patients –this is currently being delivered due tothe goodwill of the surgeon. There is aAgreement to start a weekly Friday operating list for Gynaecology at Hywel Dda UHB from mid to late April. This would be a long-term ongoing arrangement with the successful appointment of the 4th consultant. This will help reduce the waiting list of patients needing surgery at Morriston and improve waiting times for both organisations.	N/A			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 Athe Health Board and will be establishing a joint collaborative with Hywel Dda UHB for tertiary lung services following appointment of a Macmillan QI Manager at Hywel Dda. Ongoing	N/A					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. Ongoing	Actions currently being prepared and validated include: • New - Baseline review of EBUS and CT Pet Scan. • New - Queue for thoracic surgery from Decision to treat to Surgery • Update on the progress of understanding the delays between referrals written and receipted. • Update on grading processes at Moriston, Singleton, and Neath Port Talbot Hospitals. • Update data overtime reviewing number of patients awaiting grading. • Update of CT Guided biopsy numbers – broken down by Singleton and Morriston Hospital. • For USC pathway with clear definition of point of suspicion systematically develop feedback loop on the time between X ray undertaken and CT Reported As above			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. PoW AOS Service managed under Cwm Taf Health Board from 1st April 2019.	Initial AOS Steering Group held on 25th January 2019 to discuss future developments. Next meeting scheduled for 24th April 2019, which will include regional representation.			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 was appointed in October 2018 and will take a transformational approach to cancer nursing across the Health Board, 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. The Health Board's Cancer Lead Nurse and Person Centred Care Manager have developed a high level work plan identifying key work streams and actions for the next 12-18 months to provide structure to the core aims of their roles 'meeting patient needs and person centred care'. The work streams include key worker role, e-HNA, treatment summaries, CISS, health and well being and patient experience.	Macmillan Strategic Cancer Lead Nurse will take a transformational approach to cancer nursing in 2019: • Review the CNS review undertaken within cancer services in quarter 1. Extend the CNS review to collect data on CNS teams and caseload activity in quarter 2.Evaluate the efficiency and effectiveness of CNS teams in quarter 3 and Report recommendations and key themes in quarter 4.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	A103	Appointment of HB Cancer Strategic Transformation Lead Nurse.	Q1					The Macmillan Strategic Lead Cancer Nurse commenced in post on the 1st October 2018. Action Complete	N/A			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 the Health Board.	Dr Jenny Brick is a key member in the key work streams identified to provide structure to the core aims of their roles 'meeting patient needs and person centred care'. The work streams include key worker role, e-HNA, treatment summaries, CISS, health and well being and patient experience.			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. Ongoing The Health Board's Cancer Lead Nurse and Person Centred Care Manager have developed a high level work plan identifying key work streams and actions for the next 12-18 months to provide structure to the core aims of their roles 'meeting patient needs and person centred care'. The work streams include key worker role, e-HNA, treatment summaries, CISS, health and well being and patient experience.	N/A			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	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. Macmillan Cancer Support have a made a significant investment in the Health Board to improve patient and carer provision and access to cancer information and support services. This will be in the format of Macmillan information PODS in Singleton, Morriston and Neath Port Talbot Hospitals due to be installed between April and June 2019.	Cancer Information Service Steering Group has been established adn the elfare Benefits officer is a core member. The purpose of the group is to:- The purpose of the Macmillan Cancer Information and Support Service Steering Group is to: • Assure Swansea Bay UHB that the information needs of cancer patients and carers are identified, managed and delivered in the context of the All Wales Health and care Standards (WG 2015) • Provide strategic direction for the Macmillan Cancer Information and Support Service to enable the delivery of high standards and to evolve in response to patient need, patient experience and NICE Cancer Guidelines. • Oversee, ensure and provide assurance that the Macmillan Cancer Information and Support Service will contribute to meeting the Cancer Delivery Plan (2016-22), Health and Care Standards (2015) and the Swansea Bay UHB Intermediate Management 3 year Plan (IMTP 2019-22), and the Macmillan Cancer Support's philosophy of			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 the Health Board. 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.	Dr Jenny Brick is currently working with secondary care to produce a brief but relevant cancer/ treatment care summary sheet to be completed and given directly to the patient . This will encourage the patient to transfer relevant information about their treatment, management, key worker and possible side effects in a more timely way to general practice and will also be available for quicker coding. Dedicated cancer update training will be offered to the practice nurses at their protected time for learning. This will improve awareness of early signs of cancer as well as improving confidence when discussing the holistic needs of the patients after treatment, and knowing where to signpost and refer onwards.			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 is available across the Health Board via COIN. The Advanced Care planning team are providing awareness sessions and training around ACP across Primary and Secondary care. This includes, educational sessions in Singleton, Morriston and more targeted work in NPTH working closely with Olwen Morgan, Senior matron looking at frailty and associated pathways.	28/01/19, meeting held with Public health wales and 1000 Lives around their care Home Advanced Care Planning Initiative. 6 monthly report to End of Life care Board as agreed when project set up.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	A109	To further develop the Cancer Dashboard, to allow Units to self-service cancer information to assist with their planning and performance management.	Q2					Work continues to further develop/improve the dashboard. Through collaborative work undertaken by Cancer Information & Improvement and Information the CIIP was developed. Two separate views are available for USC and NUSC patients respectively to aid tracking and monitoring of patients progressing through either pathway. This visual interface of both views have been developed using information collated and input into Tracker 7. It allows the user to drill down to individual patient level, identifying the target date, current stage within the pathway and date of their next appointment. Prior to the existence of the dashboard, an excel spreadsheet was produced on a weekly basis by the Cancer Information team and distributed to the delivery units within the Health Board. The dashboard updates on an hourly basis and dramatically improve the timeliness information availability from up to seven days old to a maximum of an hour old. Demand & Capacity Modelling First OPA: Phase one was to create a suite of 'live dashboards' by which we can monitor our weekly Urgent Suspected Cancer (USC): • Referrals (demand) • Activity (number of USC patients seen at their first clinic appointment) • Waiting list (the cumulative difference between our USC demand and activity i.e. work-in-progress) • Lead-times (time from referral to first seen in clinic) • Predict future lead times (referral received to patient first seen) Currently completed live views exist for: Breast, Colorectal, Urology, Gastroenterology, Gymea Oncology, Lung, OMF and Post-Menopausal Bleed (PMB). In addition to this, prototype views have been developed for ENT, Dermatology, Haematology and Thoracic patients. These are yet to be built in the live environment by Informatics and this will happen in due course.	N/A			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 is engaged with the work of the Wales Cancer Network and the Cancer Implementation Group contributing to the national shaping of the work to support SCP implementation, and escalate potential risks. Ongoing. ABMU HB are piloting the new version of Tracker 7 before it is rolled out across other HB's in Wales. In support of data collection and reporting NWIS have been tasked to improve the tracking system (Tracker 7). Phase one of this work is to incorporate the tracking system into WPAS for all health boards, this will allow NWIS to support and develop further tracking functionality in the future as part of phase two. ABMU undertook testing in January and continues to be involved in this process and is currently on track to deploy the update to live systems in late March/early April.	N/A			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					We have initiated baseline Patient Reported Outcome Measures (PROMs) collection in Morriston Hospital with newly diagnosed lung cancer patients. attending the outpatients clinic. This is our best opportunity to work with patients to co-produce care plans that deliver the outcomes that matter most to them and ensure we provide services that deliver 'value' for our patients. In collaboration with patients, staff and colleagues from Hywel Dda Health Board lung cancer teams and the All Wales cancer network we are working to extend this collection to follow up PROMs and the initiation of PROMs collection across our other clinics in Neath and Singleton. Our Breast Cancer Team aspire to achieve the best possible Standards of Care and are in the process of initiating collection of PROMs data with patients to ensure patient care plans are tailored to delivering what matters most to their patients. The Health Board has recently appointed a Macmillan Strategic Lead Cancer Nurse in October 2018 to take a transformational approach to cancer nursing across ABMU HB, working collaboratively with the Director of Nursing, Patient Experience and Delivery Unit Nurse Directors. Additionally a Person Centred Care Manager and Macmillan Quality Improvement Manager, were both appointed in September 2018 tol 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.	Collaboration with NWIS on proof of concept work in lung cancer to design and develop PROM visualisation in clinic to enable clinical teams to easily see and review changes in PROMs. Collaboration with PKB & Healthcare Communications on proof of concept work in Breast Cancer to enable routine electronic PROM collection.	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. Ongoing	N/A			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 Q4 which is still on plan . • A strong portfolio of Commercial trials in the Urology and Melanoma setting continues to contribute to income generation. More commercial studies in other cancer areas planned for Q4 and early next financial year • 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. No scheduled teaching in quarter three . Next due in Feb 19. 4 Sessions planned over two days covering over 100 student nurses The Research Strategy for radiotherapy has been launched and regular radiotherapy research working group meetings have been established quarterly. Successful attendance continues at these meetings • 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. Phase 1 funded post commenced December2018 and monthly clinics commenced • The second year of funding for the radiotherapy research fellow has been confirmed and funding for a 2nd radiotherapy research fellow has been secured to commence December 2018. • The 2nd South West Wales Cancer Centre research day to showcase radiotherapy research is planned for November 2018. Show case well attended – with excellent feedback overall	N/A			MD		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	A114	Clinician audits to identify reasons for high usage and recommend and implement audit actions.	Q1					Antimicrobial prescribing exceptions identified by antimicrobial audits are escalated to Unit Medical Directors, for further review with prescribers. The objective of reducing use of Co-amoxiclav by 50% by March 2019 was achieved.	In June 2019, the Health Board will be participating in the ARK project (a 5-year research applied programme funded by NIHR. The overarching aim of ARK is to reduce the incidence of serious infections caused by antibiotic-resistant bacteria in the future, through substantially and safely reducing antibiotic use in hospitals). ARK-hospital is being introduced to Medicine in Moriston on June the 3rd 2019.	% 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 4, the percentage of patients that had been isolated within 2 hours of unexplained diarrhoea was 50%. • Lack of single room availability impacts on ability to isolate.	The proportion of single rooms within each site is low. During winter months, there will be competing demands for these rooms from patients admitted with influenza. Site management teams, in collaboration with infection prevention & control, will review single room utilisation daily.	40% patients with unexplained diarrhoea isolated within 2 hours of symptom onset; 100% within 24 hours.		DoN		Lead Nurse - IPC	Infection Control Committee	Quality and Safety Committee
	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					During Quarter 4, the new '4D' Environmental Cleaning/Decontamination Programme was implemented. However, it is an ongoing 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. Winter pressures exacerbated the challenge of decanting to enable cleaning.	Considerable improvements have been made to reduce the rates of HCAIs however reductions in infection rates as a result of interventions is shown over a period of months and not immediately. The Health Board continues to face significant challenges due to current demands on services and capacity alongside known pressures during the winter from infections such as influenza and Norovirus placing delivery units under additional pressure. The estate and lack of isolation facilities make managing patients with known or suspected infections a challenge which is impacted during periods of escalation.	% 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.	N/A	% compliance with algorithms		DPH		Lead Nurse - IPC	Infection Control Committee	Quality and Safety Committee
HCAI Service Improvement Plan Actions	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 4 average compliance: - PVC insertion bundle - 77% • PVC maintenance bundle - 85%.	Delivery Units to ensure clinical staff adhere to the use of PVC bundles.	10% reduction in Staph aureus bacteraemia; data to be reported for each Delivery Unit by hospital acquired cases and community acquired cases (as identified through localised surveillance).	(Q4 18/19= 45 compared with Q4 17/18= 50)	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.	Delivery Units to continue progress on ANTT competence assessments	% 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). 95% hand hygiene compliance.		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 4 – 96%. • Delivery Units commenced peer review programme.	N/A			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.	Delivery Units to continue with nursing documentation audits	% 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.	N/A			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					Audit of prevalence of urinary catheters was undertaken of the 4 acute sites in Quarter 4. PDSA improvement initiatives commenced on the 4 acute sites.. Use of bundles monitored via Care Metric. Quarter 4 average compliance: - Urinary catheter insertion bundle - 92% • Urinary catheter maintenance bundle - 93%.	N/A	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).	4% reduction (Q4 18/19= 102 compared with Q4 17/18= 105)	DPH/DoN		Lead Nurse - IPC	Infection Control Committee	Quality and Safety Committee
	A124	Hand hygiene actions as above.	Q1					Average hand hygiene compliance for Quarter 4 – 96%. • Delivery Units commenced peer review programme.	N/A	Hand hygiene measures as above.		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	N/A	% 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																
		Achievement of Annual Plan technical efficiency indicators:								Quarterly benchmarking reports (Readmission, LoS, beds, DNAs, new, follow-up)						

Corporate Priority		Action	Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Mitigating Action for Q4 if Amber or Red	Impact Measurement: Measure	Current position where numerical measures available	Responsibility and Accountability: Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance
Demonstrating Value and Sustainability Objective Measures	M29	**LoS**	Q1-4					• Combined medicine LoS has decreased on a Health Board-wide basis over the last 24 months • Bed Utilisation Review undertaken of over 780 beds or bed equivalents in October – final report received by Executive Team in partnership with LAs • Transformation Fund Bid for a Hospital2Home service submitted • ABM have continued to benchmark LOS opportunity against English and Welsh peer groups using the CHKS tool.	•Consideration of Hospital 2Home bid to WG following feedback. •Establishment of a DToC action group to address levels of DToCs and MFFD across the Health Board.	Improvement compared to Welsh peers		COO	All DUs	Head of SLR and external contracting	P&F Committee	Board
	M30	**Theatre efficiency**	Q1-4					Performance for Morriston Hospital has remained at 77% in Qtr. 4, Overall Health Baord performance has increased from 72% to 81% for the same period.	Actions are ongoing in line with the Unit based Improvement Plans which are overseen by the Theatre Efficiency Board - New Theatre redesign work scoped during March 2019	Achieve 90%		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 completed and agreement to extend pilot for a further 12 months to assess benefits as part of the modernisation programme. • 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 which has been achieved.	N/A	Achieve 10% reduction on 2017/18 eoy baseline		COO	All DUs	Service Improvement Manager, NPT	P&F Committee	Board
	M32	**New Ops - referrals**	Q1-4					The Annual Plan 2018/19 identified a driver to reduce the volume of outpatient referrals through increased use of e-referral systems within individual GP practices, and clinicians providing advice and feedback. The Primary and Community Services Delivery Unit is leading this piece of work, to move to 100% compliance with use of e-referral. • The 1% reduction in referrals target equates to 28,060 referrals per month. • In 2017/18 58.15% (120,846) of GP referrals were received electronically, 41.85% (86,969) received via paper. • In 2018/19 99,069 GP referrals have been received during April – September, 63.2% (62,612 via Electronic) and 36.8% (36,457) via paper.	The Annual Plan 2018/19 identified a driver to reduce the volume of outpatient referrals through increased use of e-referral systems within individual GP practices, and clinicians providing advice and feedback. The Primary and Community Services Delivery Unit is leading this piece of work, to move to 100% compliance with use of e-referral. • The 1% reduction in referrals target equates to 28,060 referrals per month. • In 2017/18 58.15% (120,846) of GP referrals were received electronically, 41.85% (86,969) received via paper. • In 2018/19 99,069 GP referrals have been received during April – September, 63.2% (62,612 via Electronic) and 36.8% (36,457) via paper.	Achieve 1% reduction on 2017/18 eoy baseline		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. • These plans are overseen by the Outpatient Improvement Group which in turn reports to the Planned Care Supporting Delivery Board. Each Plan has a Managerial lead for each delivery unit and who will regularly monitored through local delivery mechanisms and the Outpatient Improvement Group. • Additional funding is being released to support short term validation reviews of the FunB lists – these are being led by the managerial delivery unit lead. • An SBAR for medium to long term sustainability solution to this reduction has been approved by the IBG for additional funding to focus on validation of FunB lists. • A Gold Command has been formed to focus on Ophthalmology Follow ups and to prepare a sustainability plan and address short term solutions for long waiting patients. • The National Outpatient Modernisation Working Group has been refreshed and actively taking forward new measures to address these pressures which are being seen across Wales. Actions include improved coding, clarification of virtual clinic patients, shared learning, and stronger information reporting by specialty	Updated action plans have been received from the Morriston, Singleton and Neath Port Talbot Delivery Units. • These plans are overseen by the Outpatient Improvement Group which in turn reports to the Planned Care Supporting Delivery Board. Each Plan has a Managerial lead for each delivery unit and who will regularly monitored through local delivery mechanisms and the Outpatient Improvement Group. • Additional funding is being released to support short term validation reviews of the FunB lists – these are being led by the managerial delivery unit lead. • An SBAR for medium to long term sustainability solution to this reduction has been approved by the IBG for additional funding to focus on validation of FunB lists. • A Gold Command has been formed to focus on Ophthalmology Follow ups and to prepare a sustainability plan and address short term solutions for long waiting patients. • The National Outpatient Modernisation Working Group has been refreshed and actively taking forward new measures to address these pressures which are being seen across Wales. Actions include improved coding, clarification of virtual clinic patients, shared learning, and stronger information reporting by specialty	Improvement compared to CHKS peers		COO	All Dues	Service Improvement Manager, NPT	P&F Committee	Board
	M34	**Redesign Service pathways using VBHc approach**	Q4					COPD business case was approved by IBG and posts recruited in September. Monitoring and data requirements are being agreed. TDABC data collection has been completed and matched to outcome measures ready to submit to the All Wales Group Quarter 3 comments - Appointed into the 2 Band 6 CNS posts during October 2018, expected in post within 6 weeks. Band 7 CNS and an additional Band 6 Nurse appointed during Nov/Dec. We could not recruit to a Band 6 Physio. Expecting the team in place for Q4 2018/19. Quarter 4 comments - Team in place and working protocols agreed. Band 7 Physio post to be advertised.	N/A	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					Service Remodelling work stream now closed down, to be taken forward via HVO and Transformation Programme.	• Phased completion of NPTH and Singleton schemes as agreed by Board • Roll out of ESD for COPD	N/A		DoS	Service Remodelling Work stream	Head of IMTP Dev	P&F Committee	Board
Corporate Objective 4 - Securing a Fully Engaged and Skilled Workforce																
Securing and Fully Engaged and Skilled Workforce Objective Measures		**Achievement of Workforce Indicators:**														
	M36	**Reduction in vacancy rate**	Q1-4					• BAPIO. The Health Board has participated in the 2016 and 2017 All Wales rounds and has been successful in appointing a number of doctors across a range of specialties. In 2016 36 posts were offered and 9 doctors took up post. In 2017, 27 posts were offered with 18 doctors either commenced employment or due to take up post shortly The Health Board is participating in the 2018/19 round and have committed 39 posts for the exercise . This has been successful and 21 posts have been offered so far. • A detailed piece of work is being undertaken to analyse every medical vacancy include consultant vacancies to understand what is planned to fill these roles or to offer them up for workforce redesign. This is ongoing and will inform a comprehensive recruitment and retention strategy for the medical workforce. The January WOD Committee will consider the draft plans. Verifying the medical and dental establishments is proving problematic. It has been agreed to use pragmatism in developing the strategy whilst the more detailed work continues. •As a result of actions being taken the last 12 months to the end Dec18 has seen FTE turnover reduce for N and M staff group by 1.94% to 7.94%, compared to the same period last year. This is a significant improvement for one the most difficult to recruit to staff groups. This is also reflected in an improved vacancy gap for this staff group which for Dec 18 was 7.43% against the budgeted establishment, an improvement of 1.91% compared to the same period last year. • The Health Board continue to engage nurses from outside the UK to help mitigate the UK shortage of registered nurses. To date the Health Board has in their 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 no duplicating efforts across hospital sites. These are heavily advertised across social media platforms via the communications team. • Eleven of 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. The Helath Board has 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 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 UK. •The Health Baord has taken an active part in the Student Streamlining project and will be engaging nurse students from Welsh universities via this process.	Development and implementation of recruitment and Retention strategy for medical workforce is ongoing work for 19/20. Turnover rates for N and M remain at circa 8% a circa 1% improvement on the same time last year. A new business case has been submitted in order to secure monies to continue Overseas Nurse recruitment through 2019/20. The Helath Board is currently fully engaged in the recruiting in September 2019 newly qualified nurses from our Welsh universities via the all Wales Student Streamlining process. 150 vacancies have been made available to these students. Additional short term resource secured. Medical R&R action plan drafted for W&ODC comment. Nursing R&R plan in development. Initial findings from work with Kendall Block was well received by Exec Team. The final presentation was due on 3rd April. Final reports due on the 16th April and then the Health Baord will decide next steps Work is underway to clarify the Medical and Dental establishments to feed into the development of the Recruitment & Retention Strategy for medical staff. This is proving difficult and complex. The Health Board may need to make some pragmatic decisions about the shape of the strategy whilst the work continues around the establishment.	Reduce by 5% on 2017/18 eoy baseline		DoHR		Asst DoHR	P&F Committee	Board
	M37	**Reduce turnover within the first 12 months of employment**						The data shows particular decreases within Additional Clinical Services and the 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. •The Health Board is currently looking into the options available to manage exit interviews through ESR, this will enable the Health Board to have better access to data from staff who leave the organisation. Health Board Turnover has remained low over the last few months with a very small increase compared to the all-time low figures seen just prior to December 2018. Nurse FTE turnover remains very low hovering around 8%.	Familiarisation session planned with Workforce team regarding the ESR exit questionnaire process. This is planned in order to facilitate an improvement in overall completion of these by leavers and improve data on reasons for leaving.	Reduce from eoy 2017/18 baseline		DoHR		Asst DoHR	P&F Committee	Board
	M38	**Reduce sickness absence**	Q1-4					The 12-month rolling performance to the end of February 2019, has continued to follow the improvement achieved in January and currently stands at 5.92% (down 0.03% on January 2019). This is running above the all Welsh average of 5.5%. Long-term absence in February 2019 stands at 4.50%, which is down 0.08% on January 2019. For the first time this year, February's long-term absence performance has seen, three out of five-delivery units improve their long-term position, with Singleton delivery unit decreasing the most by 0.5% since December 2018. This reduction in long-term absence coincides with the confirm and challenge sessions that are being held with delivery units. Short-term absence reduced by 0.58% between February 2018 and February 2019. With an increase of 620 short-term cases, and a decrease of 2,247 FTE hours, between February 2018 and February 2019. Demonstrating early intervention techniques adopted from the Health Board's best practice case study are experiencing a quicker return to work date. ACTIONS BEING TAKEN • Outputs of best practice case study conducted in three areas of good sickness performance, are being incorporated into each DU's attendance action plans. • Development of a pilot within Morriston facilities department has commenced, implementing best practice from the above case study and re-deployment of resources have been placed to best facilitate these practices. • Training sessions for managers regarding the new all-Wales Managing Attendance policy have been extended until June 2019. • Development of a full training plan to support implementation of the new Attendance policy. • OH Improvement Plan completed with targets for reductions in waiting times approved by Exec Board. Plans to develop a more multidisciplinary approach during 2019. • Delivering Invest to Save 'Rapid Access - Staff Wellbeing Advice and Support Service' enabling early intervention for Musculoskeletal (MSk) and Mental Health, ideally within 5 days (90 referrals monthly) and expediting to MSk diagnostics and surgery when required. This model accepted as Bevan Exemplar 2018/19. • Currently implementing digital dictation software for clinicians to reduce waits for OH reports to be sent to managers. Evaluation to be completed July 2019. • 300+ Staff Wellbeing Champions now trained to support their teams health and wellbeing and signpost to Health Board support services, promoting a prevention/early intervention approach. • Deliver 'menopause wellbeing workshops' across four main sites during 2019. • Amendments to Swansea Bay's attendance action plan are underway to be re-submitted for sign off by W&OD committee.	Increasing OH secretarial support to reduce waiting times for reports to be sent to managers. Reducing the number of Medical follow-up appointments to reduce waiting times for management referrals. Using OH resource release opportunities to develop more prudent, multi-disciplinary model to ensure all health professionals work to 'top of licence.' Staff flu campaign resulted in 54% of frontline staff being vaccinated (8580 vaccinations administered). Continued development of the WG Invest to Save Staff Wellbeing Service - recent review demonstrates 90 monthly referrals of which 70% are for mental health conditions and 30% musculoskeletal conditions. Four Menopause workshops for staff are being delivered between March and June 2019. Continued delivery of Mental Health awareness sessions to managers. To date 24 sessions have been delivered to 209 managers. Continued further delivery of Work related stress risk assessment training for managers. To date 32 sessions have been delivered to 267 managers in total.	Reduce by 5% on 2017/18 eoy baseline	The 12 month rolling performance to the end of February 2019 5.92%.. Our in month performance in March 19 was 6.13%	DoHR		Asst DoHR	P&F Committee	Board
	M39	**Improve PADR compliance**						PADR Compliance remains stable and has fallen to 65.93% in March 2019 from 66.8% in February 2019. The PADR compliance rates have seen a steady improvement since April 2018 when the Health Board compliance was recorded at 62.18%. All Service delivery units are currently amber at over 65% compliance. NB compliance level will need to be reworked following the BBC transfer. Mental Health & Learning Disabilities 74.42 Morriston Hospital 68.73 Neath Port Talbot Hospital 81.84 Primary Care & Community 77.95 Princess of Wales Hospital 65.44 Singleton Hospital 70.97 All Service Delivery Units have been asked to write a plan for increasing their compliance levels. With the boundary change and impact of organisational restructure, maintaining this level of PADR compliance will remain a challenge until structures are stabilised and the roll out of ESR self and supervisor self-service are complete.	Service pressures and time are cited as the biggest challenges for managers and staff in undertaking PADRs and this has been further exacerbated in due to the impact of the Bridgend Boundary Change. Reporting through ESR, as the only mechanism, raises challenges as this can only be completed by line managers who are assigned structures and access via Supervisor Self Service. As a temporary alternative option some areas have identified administrators who are trained to enter data on ESR through administrator access rights. It should be noted that a number of the areas of low compliance are 'hosted' bodies, including EMRTS, Delivery Unit, Clinical Medical School and Clinical Research Unit. As such there is no direct control over their PADR activity and compliance rates. It should also be noted that Board posts are included in the Board Secretary assignment count. As such the % compliance is not an accurate reflection of the compliance level of the Board Secretary's direct team.	Achieve 85% target	65%	DoHR		Asst DoHR	P&F Committee	Board
	M40	**Improve mandatory and statutory training compliance**						Over the past month compliance against the 13 core competencies has risen 75.22% (March 2019). This is a 1% increase from the previous month and a 19.80% rise since April 2018. This improvement has come from focused interventions including: - Uploading of competencies - Mapping competencies to ensure the recognition of prior learning - Work with national team on inter authority transfers and accurate data Focused work in areas such as facilities and estates departments. Medical staff will be an area of targeted working in the first quarter of 2019. Outcome of re-audit received. Audit rating has improved from limited to reasonable assurance.	The recent re-audit of previous IA recommendations reports an improved level of assurance which is now reported as reasonable assurance. The Mandatory Training Governance Committee has a planned meeting of 31st May to discuss content, recording, regular meetings arranged and compliance Once clarified, this would then be subject to approval via the Executive Team • All staff that require Learning Administrator Access have been trained and have been recorded within ESR • Due to the impending change of boundaries the work involved in Position numbers has taken a back step, however, will become a higher priority as we move forward identifying further training that are essential for specific areas of work and for this to be included in ESR staff competencies requirements	Achieve 85% target	75%	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. The roll out is commencing from 1st May. Roll out of E job planning has commenced. Both projects are supported by WG and TI intervention. Project staff have been recruited and commenced post February/March 19. This has enabled the rollout of both projects. • The Health Board has engaged with Kendall Block via Medacs to undertake a deep dive into the ED Depts. at Morriston and Neath and to undertake a review of all junior doctor rotas across the Health Board to maximise efficiency in rostering all junior doctors which should lead to a reduction in agency and AOH spend. Work is underway and the results were presented to the Exec Team on the 27th February and 3rd April. Final reports are due on the 16th April. • Work is underway with Medacs to review every long standing locum booked over 3 months to understand if they can be replaced with a more cost effective locum and what the plans are to fill on a substantive basis. Work ongoing, recently supported by correspondence from the EMD and COO instructing the DUs to use Medacs as there has been reluctance. This is tied to the emerging work on the medical R&R strategy presented to the WOD Committee. • Review of data collection from agency diagnostic tool, develop plans to implement findings.	Projects on track but due to the need to recruit have not stated yet but this will over the next two months. KB work on track. Medics work ongoing but bolted by the EMD and COO due to the DUs reluctance to use Medacs	Reduce by 10% from eoy 2017/18 baseline		DoHR		Asst DoHR	P&F Committee	Board
	M42	**Workforce and OD Strategy in place**	Q4					A Workforce & OD Framework has been developed in draft. And shared with the newly formed Workforce & OD Forum. The Framework supports the Health Board's operating framework and is underpinned by the organisational values.	N/A	Strategy in place		DoHR		Asst DoHR	P&F Committee	Board
	M43	**Improvement in staff engagement**	Q4					Preparation is underway for the annual showcase staff celebration, Chairman's VIP Awards, to take place on 6th June 2019. Shortlisting for all categories has taken place and public voting is currently underway. For the first time this year, the medical trainee awards is included within the Awards programme. Patient Choice and farewell event took place at Princess of Wales Hospital in March 2019 to celebrate the great work of staff transferring to Cwm Taf Morgannwg University Health Board on 1st April 2019. The NHS@70 celebrations were officially concluded in March 2019 with the unveiling the NHS@70 Time Capsule at Morriston Hospital Outpatient Department. The Time Capsule was jointly commissioned and designed by an apprentice at Tata Steel and included memorabilia from multiple teams with instructions to be opened on the 100th anniversary of the NHS in 2048. THE leadership programme 'Footprints' which focuses on behaviours and workplace culture has been shortlisted for a national HPMA Award. Positive messages on Staff survey with staff contributing to development of actions through October, November and December using a variety of methodologies to promote accessibility and capture what matters most to staff. Engagement is complete and list of priorities and actions shared with Partnership Forum, Workforce & OD Committee and Executive Team. Actions have been identified against three themes: Healthy Workplaces and Wellbeing, Great Leaders Great Managers, Innovation Learning & Development. Pilot areas are to be identified and work commences immediately.	The Health Board will assess the impact of staff engagement activities through the next NHS Staff Survey when this is agreed nationally. Other actions include: Support for the introduction of an independent 'freedom to speak up model' to enable staff to speak up in confidence in relation to any worry or risk in the workplace. Procurement for this independent resolution-focused service process has been completed and the contract has been awarded to The Guardian Service Ltd. Appointment of dedicated Guardians for Swansea Bay University Health Board is currently underway along with detailed commissioning work to set up the service during April with a go live date of May 2019. Commissioning ACAS to work with the Health Board from November 2018 through to August 2019 to run workshops for HR, Trade Unions and line managers. These workshops have been well received. The aim of the ACAS workshops has been to equip staff with people management responsibilities, with additional tools to benefit them in their day to day roles, particularly in dealing with difficult people management situations of a bullying nature. The focus is on creating a workplace and culture where appropriate behaviours are promoted and supported. It was initially targeted at those areas where the NHS Wales Staff Survey had confirmed a 20% or higher response rate to the bullying and harassment questions, however this training has now been opened out to all areas and is combined with the new Managing Attendance at Work Policy and promoted as a full-day People Management Skills Programme. All HR & trade union workshops are now complete. Originally 10 line manager workshops were planned. So far, 7 out of the 10 have been completed with 82 managers attending. The remaining 3 workshops are fully booked. Due to the success of the workshops, a further 10 workshops have been commissioned and these will run March through to August 2019.	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					Workforce capacity remains challenging and continues to be a risk and constraint particularly in ED and medical specialities, alongside nursing in key areas such as MIU and medical wards. The ability to safely core and surge bed capacity has been particularly difficult this winter with non contract agency staff utilised at times to mitigate the risk. Some of the service redesign proposals have been implementing different roles such as physician associates, generic workers, created new band four roles to support patient flow.	Some of the winter pressures funding has also supported the provision of extended cover/capacity particularly in therapy/pharmacy and support service roles. The hEalth Baord iscontinuing to recruit and to try and attract staff to work within this Heath Board but the availability of staff in some key clinical services remains an ongoing challenge.	Achievement of Workforce Improvement Indicators. Achievement of actions outlined above.		COO/DoHR		Asst COO	USC Service Improvement Board	P&F Committee
Stroke Service Improvement Plan Actions	A127	Explore opportunities to expand targeted 7 day cover through workforce redesign	Q1-4					To be taken forward through the planning process to develop the HASU. Amber status will remain until HASU plans finalised.	Ensure HASU project has clear terms of reference to include 7 day cover as part of the overall design of the clinical model.	Increase the number of generic roles.		DoHR		Assoc Dir R&S	USC Service Improvement Board	P&F Committee
	A128	Recruitment to 2nd SPR in Morriston to support 4 hour bundle.	Q2					6 additional middle tier medical staff have been appointed at Morriston.	Appointments made to the Unit - but other vacancies are reducing the impact of these appointments with staff working down into other posts to cover duties.	SpR appointed		COO		Assoc Dir R&S	USC Service Improvement Board	P&F Committee
	A129	Continue staff training and awareness sessions of stroke pathway	Q1-Q4					SLT training sessions have been undertaken in Morriston • The new middle tier of medical staff (referred too above) are in the process of receiving thrombolysis training.	ED staff have undergone Swallow assessment training	Evidence of staff who have received stroke training awareness sessions.		DoHR		Assoc Dir R&S	USC Service Improvement Board	P&F Committee
	A130	Continue training and awareness in communication skills and advance care planning.	Q1-Q4							Improve End of Life Care		DoT		Assoc Dir R&S	USC Service Improvement Board	P&F Committee
HCAI Service Improvement Plan Actions	A131	Review funding allocation for DU rapid Response Teams to undertake the cleaning and decontamination of all equipment and environments, releasing nurses' time for patient care activities.	Q2					No further progress made	Escalation to Health Board's Quality & Safety Committee. Swansea Bay University Health Board Environmental Decontamination Task & Finish Group established in April 2019, which will report to the Decontamination Sub-Group of the Infection Prevention & Control Committee. Remit of this T&F Group will be to review and make recommendations on environmental hygiene and decontamination.	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. Impact of Boundary Changes to be worked through.	Impact of Boundary Change will result in a reduced budget. IPC Service redesign to be reviewed, to propose a service for the future of services delivered by the Health Board	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.	Impending Boundary Change restricts further development at present. Primary Care & Community Services reviewing initiatives to reduce infections within the community.	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.	N/A	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.	In June 2019, the Health Board will be participating in the ARK project (a 5-year research applied programme funded by NIHR. The overarching aim of ARK is to reduce the incidence of serious infections caused by antibiotic-resistant bacteria in the future, through substantially and safely reducing antibiotic use in hospitals). ARK-hospital is being introduced to Medicine in Moriston on June the 3rd 2019.	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 9 tracker indicates that most areas are not delivering against the plans. • Mitigating actions have been agreed to support the achievement of control total	A six month review of actions was completed in October and further key actions identified for year end A new work stream has been established to bring together all of the elements of medical workforce actions including a detailed review of junior doctor and ED rota's; implementation of locum on duty and e-job planning and other actions Units have been asked to identify mitigating actions to offset non delivery of savings and these are being managed through regular Performance, Quality and Finance meetings	Savings assessment		DoF	R&S Programme Board	Deputy Dir R&S		P&F Committee
	M45	**Achievement of the agreed financial control total in 2018/19 and continued development of a plan to achieve financial breakeven**	Q4					Year end position £9.879m overspend, therefore £10m control total target was achieved.	N/A	Financial control total		DoF		Asst DoF		P&F Committee
	M46	**Enabling and supporting plans delivering required improvements (to achieve financial control total)**	Q1-4					Savings of £13.3m delivered against savings target of £16m. This was 25 forecast and mitigating actions and opportunities were identified to manage the shortfall.	N/A	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					Capacity was successfully secured across multiple providers, mitigating the risk of sole reliance on a single point of delivery. The planned outsourcing was delivered and supported the achievement of the 36 week target at year end.	N/A	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	N/A	Signed agreed documents		DoS/DoF		Asst DoS	JRPDC	Board
	A138	Agree models of service where workforce can be shared.	Q2					Regional planning discussion are considering options for workforce sharing. To date there are examples in endoscopy, dermatology and vascular where joint working has been effective.	Regional Planning work is ongoing	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					Progress made including treat and repatriate model for cardiology which sine it's introduction has seen a significant reduction in waits for treatment for ACS cardiology patients.	The cardiology model is being shared with the vascular network to see what learning can be adopted for other pathways.	Signed off pathways in place and operational		COO		Asst DoS	JRPDC	Board