Appendix A. Annual Plan Progress Report Qu1 2018/19

Actions and timescale									Impact Measurement		Responsibility and Accountability				
Corporate Priority	Action		Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures	Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance
Corporate Objective 1 - Promoting and Enabling Healthier Communities															
Promoting and Enabling Healthier Communities Objectives Measures	M1	**Wellbeing and Area Plans in place**	Q1					Western Bay Area Plan agreed at Health Board in March 2018 Public Service Boards Wellbeing Plans and Plans for ICF have been agreed through an inclusive process	Plans approved		DoS	Western Bay RPB	Asst DoS	Planning, Commissioning and Strategy Group	Board
	M2	**Clinical Services Strategy Approved**	Q3					Currently being drafted. Tender document prepared for external supporting work.	Strategy approved		DoS		Head of Value and Strategy	Planning, Commissioning and Strategy Group	Board
	M3	**Organisational Strategy Approved**	Q3					In development and the Health Board is commissioning further support to develop.	Strategy approved		DoS		Head of Value and Strategy	Planning, Commissioning and Strategy Group	Board
Unscheduled Care Service Improvement Plan Actions	A1	Increase uptake of all childhood vaccinations. Local Public Health Team to support increased uptake in the following ways: Deliver immunisation awareness training for pre-school settings to promote key vaccination messages Contribute to the implementation of recommendations made in the "MMR Immunisation: process mapping of the child's journey" report Continue to promote the benefits of immunisation through Healthy Schools and Pre-Schools e-bulletins Develop local resources/ products to share good practice	Q1-Q4					Children's Immunisation Group (ChIG) to review terms of reference, workplan and reporting mechanisms to SIG. To continue to monitor data processes to ensure accuracy of data.	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		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					Review of local Tobacco Control actions against National Tobacco Delivery Plan in progress. Review of the three ABM cessation services to be undertaken as part of national integration agenda and against minimum service standards being developed on an all Wales basis. Undertaking local service review of Hospital Stop Smoking Service for completion by mid August. Hospital Stop Smoking Service targets inpatients with respiratory conditions, heart disease, pre-operative care and staff. Hospital Stop Smoking Service exceeded its targets for April and May 2018.100 Community Pharmacies commissioned from April 2018 to deliver the level 3 smoking cessation service - plan in place to address performance, service development and quality improvement. The three ABM cessation services are falling slightly below the HB trajectory for smoking cessations services for April and May 2018.	Review of Tobacco Control against National Tobacco Delivery Plan Review of ABMUHB cessation services Achievement of HB trajectory for smoking cessation services.	April - May 0.46% of smoking populations became treated smokers with ABM Cessation Services (monthly trajectory to meet 3.2% target is 0.53%)	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					Following a review of the 2017/18 flu season, agreed actions within the primary care flu planning group are being finalised for the forthcoming season	Increase uptake to 55% from 45% Achieve WG target (75%) for individuals aged 65 years and over	N/A	DPH		Immunisation Coordinator	USC Service Improvement Board	P&F Committee
	A3	Improve access to dental care	Q4					A formal tender process undertaken in Nov 2017 resulted in 15,302 additional UDAs (£367,248) awarded to practices across ABM. In addition, in the NPT area, a new contract for 12,500 UDAs (£300,000) was awarded to a new dental provider, due to open Oct/Nov 2018. Anticipated this level of commissioning should see a progressive improvement in access to general dental services throughout 2018-9. Due to considerable issues around recruitment of GDPs over previous 6 months in some contracts, with positions remaining vacant 3/4 months+ , this will have impacted on access/activity levels at the start of April 2018. With new GDPs being recruited it is expected the 2nd quarter of the year will see activity/access rise. Also, there is a 2 month period for claims to be submitted following completion of treatment therefore full data will only be available when all FP17 forms have are processed for May/June i.e. August.	Improve on 201718 baseline as measured through GDA statistics	Awaiting publication of Q1 data	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, preparation of a full business case is being prepared for presentation to the IBG in October. CVD Risk Assessment delivered within 3 practices of North Cluster to date.	Reduce variation practice to practice by Cluster Network		COO	PCS DU	IMTP Lead PCS	USC Service Improvement Board	P&F Committee
	A6	Improve access to services to support mental wellbeing as part of the implementation plan for the Strategic Framework for Adult MH and the plans for new Health and Wellbeing Centres	Q4					Plans for Wellbeing Centres in development through Primary Care and ARCH teams	Measures TBC as part of the development of Health and Wellbeing Centres		DoS	ARCH Programme Board	Head of Service Planning - ARCH	USC Service Improvement Board	P&F Committee
Stroke Service Improvement Plan Actions	A7	Implement the DOAC service	Q2					Proposal received by IBG and project manager in place	Increase the number of patients on anti-coagulation therapy on 2017/18 baseline.		COO	PCS DU	IMTP Lead PCS	Stroke Service Improvement Board	P&F Committee
	A8	Smoking cessation (See USC plan)	Q4					See action A2	See USC plan		DPH				
	A9	Increasing levels of physical activity in key target groups, including staff	Q4					Workshop held in February 2018 to develop action plan in response to physical activity strategy. Key partners have committed to working on actions.	Action plan developed in response to Physical Activity Strategy.		DPH		Principal Public Health Practitioner	Stroke Service Improvement Board	P&F Committee
	A10	Increasing proportion of population of a healthy weight.	Q4					Nutrition Skills for Life continue to support delivery of Foodwise Weight Management Programme by NERs and Community Groups. Pilot of Foodwise being delivered in Swansea Cluster. Limited Weight Management Programmes delivery across HB continues.	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					Advocated for Wales inclusion in the European Health Literacy Survey is starting in 2019. Embedded health literacy information into Making Every Contact Count and Co-production programmes and training. Exploring health literacy training options. Swansea primary care cluster planning a focus group with patient involvement and voluntary sector support on improving health literacy communication.	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					Developed plan for sustainable approach to MECC in ABM area. Training materials and resources reviewed and updated.	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 at Q1	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					In preparation for the implementation of the Single Cancer Pathway, the Service Improvement Practitioner for Cancer has begun Demand & Capacity modelling work to support the Singleton Delivery Unit who manage the endoscopy service across the three sites. Data has been extracted from our hospital systems with validation and analysis to begin week commencing 16th July 2018. Meetings have been held with Pathology to undertake similar work.	Reduce USC and NUSC referral rates.	Average number of USC referrals received over 13 mth period May 2017 - May 2018 = 1810 Increased number of USC referrals in May 2018 = 2055	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					The H&N MDT has been actively involved in promoting HPV vaccination for boys in Wales and has been liaising with Tenovus regarding this. With the recent announcement that the JCVI is likely to recommend against vaccination for boys the MDT has wholeheartedly supported an urgent public response on an All-Wales basis to highlight our professional concern and desire to see Wales lead the way in vaccination for boys in the UK.	Reduce referral rates		COO		Cancer Quality and Standards Manager	Infection Control Committee	Q&S Committee
	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. No other information on this campaign.			DPH	PCS DU	Principal Public Health Practitioner	Infection Control Committee	Q&S Committee

Corporate Priority		Action	Timescale	Progress Q1	Progress Q2	Progress Q3	Progress Q4	Quarterly commentary on progress	Impact Measurement: Measure	Impact Measurement: Current position where numerical measures	Exec Lead	Responsibility and Accountability: Delivery lead - mechanism	Responsibility and Accountability: Monitoring lead	Responsibility and Accountability: Reporting and monitoring	Responsibility and Accountability: Board Governance
HCAIs Service Improvement Plan Actions	A20	Adopt All Wales Urinary Catheter Passport.	Q2					Catheter passport widely used in the Health Board. Some staff awaiting training which is now included in catheterisation training. Catheterisation policy awaiting ratification - the use of the catheter passport is included in the policy.	% reduction in Co-Amoxiclav usage across the Health Board in 2017/18 baseline.		DPH/DoN		Lead Nurse - IPC	Infection Control Committee	Q&S Committee
	A21	Develop and implement restrictive antibiotic policy.	Q1					Restrictive antimicrobial policy introduced on June 12th.			DPH/DoN		Lead Nurse - IPC	Infection Control Committee	Q&S Committee
	A22	Audit & feedback of antimicrobial usage.	Q1					The bi-monthly audit and feedback of antimicrobial use (secondary care) has been suspended in this quarter to allow pharmacy staff to focus on implementing the introduction of the restrictive antimicrobial policy. All Co-Amoxiclav prescriptions outside of guidance must be approved by a Consultant; also, all Co-amoxiclav prescriptions outside of guidance are reported to the Unit Medical Directors.	% reduction in acid suppressant usage across Health Board on 2017/18 baseline.		DPH/DoN		Lead Nurse - IPC	Infection Control Committee	Q&S Committee
	A23	Review pathways for patients with biliary tract disease (Simon Weaver - POW)	Q1								DPH	POW DU		Infection Control Committee	Q&S Committee
Corporate Objective 2- Delivering Excellent Patient Outcomes, Experience and Access															
	M4	**Refresh our Quality Strategy and approach to Quality Improvement**	Q4					On hold pending new DoN and MD taking up post	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 the Health Board Unscheduled Care (USC) improvement plan and is overseen by the reconstituted USC delivery board. • The Health Board is working towards the implementation of the discharge improvement plan developed in response to WAO discharge report. • The Health Board is increasing communication and awareness of the impact of delayed discharge on patient outcomes (deconditioning). • The Health Board is participating in and promoting the national #EndPJparalysis campaign between April and July 2018, which was launched at Morriston hospital by the Chief Nursing Officer in April 2018. A full evaluation of the impact of this campaign will be reported to the USC board in August. Metrics to monitor improvements in patient flow include: • The number and percentage of patients who have an EDD • Readmissions within 28 days of discharge • The percentage of patients discharged before midday.	Patient Flow metrics collected via Patient Flow Dashboard		COO	All DUs	Head of PE, Risk and Legal Services	USC Service Improvement Board	Q&S Committee
	M6	**Roll out Comprehensive Geriatric Assessment**						Plans to enhance and develop frailty models within existing resources continue and include: • Accelerated placement team in NPT • Support for the development of the ICOP service in Singleton • Embedding and developing the redesigned frailty model at PoW • Enhancing the frailty model at Morriston through increased physio and social work support. The intermediate care consultants all proactively undertake Comprehensive Geriatric Assessment's. Ongoing implementation of HB wide frailty models of care to support and promote improved patient outcomes and quality of care.	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**						During quarter one of 2018/19, 1030 inpatients falls were reported in total. Of these, 359 results in harm to the patient. For the same period in 2017/18, 1183 inpatients falls were reported in total, with 432 causing harm to the patient. This indicates a Health Board reduction in inpatient falls causing harm. The Falls Prevention and Management Group continue to meet monthly. The annual falls work plan for 2018/19 includes recommendations from the National inpatient falls audit and will be monitored regularly through the group. The Falls Policy and associated documentation has now been reviewed and revised which was completed with full engagement of all delivery unit falls representatives. The revised draft policy and associated documentation has been successfully trialled on wards within Princess of Wales Service Delivery Unit. The final draft policy incorporates all recommended guidance from NICE and the recommendations from the 2017 National Inpatients Falls Audit. The policy will be presented at the July 2018 Quality and Safety Forum for final comments, followed by submission to the Quality and Safety Committee in August 2018 for ratification.	Reduction in number of falls on 2017/18 baseline - from Quality Dashboard	13% reduction in falls Q1 18/19= 1,016 compared with Q1 17/18= 1,173)	DoN	All DUs	Head of PE, Risk and Legal Services		Q&S Committee
		Improve outcomes following stroke						See Action No O16-O19	NHS Wales Outcomes Measures						
	M8	**Improve End of Life Care**						Ongoing actions through the End of Life Steering Group	Metrics from the Quality Dashboard (TBC)		DoT	All DUs	Head of PE, Risk and Legal Services		Q&S Committee
	M9	**Improve Surgical Outcomes** **1. National Emergency Laparotomy Audit** **2. Lower limb amputation for peripheral arterial disease** **3.Enhanced Recovery after Surgery**						Measures in development	1. NELA 2. National Vascular Registry Data 3. ERAS metrics		DoT	Exec Lead	Head of PE, Risk and Legal Services		Q&S Committee
	M10	**Reduce pressure ulcers**	Q1-4					During quarter one of 2018/19, the Health Board reported that 135 pressure ulcers developed in our hospitals, with 40 of these being graded as 3, 4 or un-stageable (3+). For the same period in 2017/18 , 174 pressure ulcers reportedly developed in our hospitals, with 64 graded as 3+. This indicates that the Health Board is reducing the number of inpatient pressure ulcers. For community developed pressure ulcers, the Health Board reported 228 pressure ulcers in total, with 75 graded as 3+ during quarter one of 2018/19. For the same period in 2017/18 a total of 235 pressure ulcers reportedly developed in the community, 66 of these graded as 3+. This indicates that the Health board has reduced the amount of grade 3+ pressure ulcers developing in the community. • The Pressure Ulcer Prevention Strategic Group meeting (PUPSG) was held in June 2018. PUPSG are continuing to work closely with Welsh Risk Pool to deliver the Health Board Pressure Ulcer Strategic Quality Improvement Plan. • An Independent review of Welsh Government Serious Incident reportable pressure ulcers for 2017-18 was presented at PUPSG in June. The review examined 164 incidents and identified 23.2% cases as being avoidable and 65.5% as unavoidable. • The review utilised the causal factor map developed by PUPSG and offers strong assurance that it is a valid tool for the identification of work streams to reduce avoidable pressure ulcers. The causal factor analysis also provides insight for individual Service Delivery Unit's (SDU's) to focus on location specific work. • The most common causal factor for avoidable pressure ulcers was identified as inadequate frequency of patient repositioning. The revised Prevention and Management of Pressure Ulcers Policy clearly identifies the minimum requirement for repositioning for in-patients. However, the frequency of	Reduction on 2017/18 baseline through Quality Dashboard	16% reduction in pressure ulcers Q1 18/19= 363 compared with Q1 17/18= 434	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				
Delivering Excellent Patient Outcomes, Experience and Access Objective Measures		**Deliver the Targeted Intervention Priority Improvement Trajectories:**													
		Unscheduled Care													
	M11	**The percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge**						Unscheduled care performance against the 4 hour target was 81.02% in June, which was the best HB wide performance against this measure since September 2017. 4 hour performance improved month on month during Quarter 1 but remains fragile and has not achieved the HB trajectories for improvement. The overall number of patients attending our ED's and MIU's during June increased by 521 attendances or 3.3% when compared with June 2017. The delivery units are continuing to implement their USC improvement delivery plans.	NHS Wales Outcomes Measures	81.02%	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**	Q1-4					477 patients stayed over 12 hours in our Emergency departments during June 2018, which represented a 24% reduction from May and there has been a month on month improvement against this measure during Q1. However the number of patients awaiting admission, discharge or transfer from our emergency departments increased by 29% when compared with June 2017 and performance has not yet achieved the internal traiectories set by the HB.		476	COO	MDU, POW DU	Asst COO	P&F Committee	P&F Committee
	M13	**The percentage of emergency responses to red calls arriving within (up to and including) 8 minutes**						Health Board Category A performance was 78% in June 2018 which exceeds the National target of 65%.		78%	COO	MDU, POW DU	Asst COO	P&F Committee	P&F Committee

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	M14	**Number of ambulance handovers over one hour**						The number of >1 hour handover delays for patients arriving by ambulance has seen a month on month reduction during Q1. However performance against this measure has not achieved the internal trajectories set by the HB.		351	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					Unscheduled care pressures continue to compromise ability to move patients in a timely fashion	NHS Wales Outcomes Measures	40%	COO	MDU, POW DU	Assoc Dir R&S	Stroke Service Improvement Board	P&F Committee
	M16	**CT Scan (<1 hrs)**						Progress being achieved		51.30%	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)**						We do not have a dedicated Stroke OOH rota - which is the area we currently struggle to deliver this target against.		88.20%	COO	MDU, POW DU	Assoc Dir R&S	Stroke Service Improvement Board	P&F Committee
	M18	**Thrombolysis door to needle <= 45 mins**						Eligible patients receive their Thrombolysis consistently within the target - but further work is required to deliver to this target		37.50%	COO	MDU, POW DU	Assoc Dir R&S	Stroke Service Improvement Board	P&F Committee
		Planned Care													
	M19	**The %age of patients waiting less than 26 weeks for treatment**	Q1-4					Whilst we are not achieving the national target of 95% or the health board profile of 89.2%, the percentage has increased in Q1 from 87.82% to 88.69% demonstrating a slight improvement. This is also an improvement compared to the Q1 position in 2017/18.	NHS Wales Outcomes Measures	88.69%	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**						The health board was ahead of the March 2018 position and the health board profile at the end of Q1 demonstrating slight improvement.		3319	COO	All acute DUs	Asst DoS	Planned Care Service Improvement Board	P&F Committee
	M21	**The number of patients waiting more than 8 weeks for a specified diagnostic test**						The health board did not deliver against the profile of Nil at the end of Q1. Excluding the previously unreported suite of cardiology diagnostics, the deterioration was reported within the specialty of non-obstetric ultrasound as a result of workforce issues. Plans to outsource as an interim measure are in place to recover the position in Q2 whilst a sustainable solution is sought.		915	COO	All acute DUs	Asst DoS	Planned Care Service Improvement Board	P&F Committee
	M22	**The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date**						The health board did not deliver against its profile at the end of Q1 although in-month performance has slightly improved for both follow up booked and not booked. Q2 plans are expected from each of the service delivery units demonstrating improvement and to ensure that the highest risk patients are not being harmed as a result of the delay.		63,776	COO	All acute DUs	Asst DoS	Planned Care Service Improvement Board	P&F Committee
		Cancer													
	M23	**The percentage of patients newly diagnosed with cancer, not via the urgent route, that started definitive treatment within (up to and including) 31 days of diagnosis (regardless of referral route)**	Q1-4					All actions in the Cancer Service Improvement Plan are being undertaken to improve performance. Performance monitoring is in place through the Cancer Service Improvement Board to monitor risks and review the Units' detailed improvement plans.	HB trajectory is 98% (WG target)	96.00%					
	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**						All actions in the Cancer Service Improvement Plan are being undertaken to improve performance. Performance monitoring is in place through the Cancer Service Improvement Board to monitor risks and review the Units' detailed improvement plans.	HB trajectory is 90% (WG target is 95%)	84.00%					
		HCAIs													
	M25	**Achievement of C.Difficile trajectory (15 % reduction)**	Q1-4					23% fewer cases of C. difficile infection than the equivalent period in 2017/18.	NHS Wales Outcomes Measures	22% reduction (Q1 18/19= 59 compared with Q1 17/18= 76)	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)**						13% more cases of Staph. aureus bacteraemia than the equivalent period in 2017/18		13% increase (Q1 18/19= 54 compared with Q1 17/18= 48)	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)**						5% fewer cases of E.coli bacteraemia than the equivalent period 2017/18		4% reduction (Q1 18/19= 126 compared with Q1 18/19= 131)	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					**Learning Disability Services** Agreement with commissioning Health Boards on broad service model and direction of travel. Meeting between directors of Finance for 3 health boards in September which will determine commencement of envisaged changes to Hafod Y Wennol as part of overall modernisation. Agreement given for meetings with partner local authorities in Cardiff and vale and Cwm Taf regarding future service model and Delivery unit engaged in this. **Older People's Mental Health Services** Outcome of public engagement positive. Cross locality modernisation group with 3 local authorities is ongoing regarding future shape of service. Proposals for enhancing care home in reach across 3 local authority areas submitted to Welsh Government. WG Dementia funding routed through Western Bay and decisions therefore to be made in RPB regarding use of dementia action plan funding. **Adult Mental Health** Strategic Framework still to go back to Health Board for final sign off. Development of recommendations for future service model, developed in partnership with local authorities, based on Strategic framework delayed. Funding from Western Bay for implementation role agreed to support this so anticipate that pace will pick up although boundary change has an impact when working across current footprint for future change. Funding proposal to further develop early intervention in psychosis service and make CRHT advise and assessment service 24 hour in each local authority area submitted against Welsh Government funding. Funding proposal for addressing current waiting list for high intensity psychological therapies in 2017/18 and change service model for future years	Measure TBC		COO	MHLD DU	Head of Planning and Partnerships	MHLD Commissioning Board	P&F Committee
	A24	Maximise use of 111 model	Q1-Q4					Annual report on performance against 111 interim standards submitted to WG.. Some performance against call response times to be addressed. Skillmix changes to GPOOH and further modernisation of the service underway with 6 month work programme in place. Paramedic calls to GPOOH have increased with a corresponding decrease in category 3 conveyances to hospital.	Meet NHS Wales outcomes standards for GP access Roll out Integrated hub model of primary care Reduce healthcare, professional and Amber 2 ambulance conveyances to hospital from 2017/18 baseline Implement Primary Care Estates plans for 2018/19		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					As above changes to GPOOH, including widening of skill mix, and introduction of remote triage to create a more sustainable service re underway with an initial 6 month work programme.	Implement OOH changes		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					Additional community pharmacist support now available for day and OOH period. Forming core part of first self care response and OOH assistance. This is part of the ABMU Winter Plan for 2018/19. Vaccination delivery programme for care homes is part of the Annual Flu Delivery Plan. Access for Care Home Staff to receive vaccination is being made available through community pharmacies opting into the scheme. Progress will be monitored through the Winter Flu planning team.	Measures TBC		COO	PCS DU	Nurse Director PCS DU	USC Service Improvement Board	P&F Committee
	A27	Maximise impact of Community Resource Teams and community rapid response models on patient flow	Q2					This is part of the ABMU Winter Plan for 2018/19. ABMU Has an integrated Frequent Flyers Service for Swansea City with acute, community, social care and third sector involvement who also link with Community Resource Teams. This supports the collaborative approach across units and agencies. The group identifies patients whose needs are increasingly accessing the Emergency department. For 2018/19 this arrangement is being developed further to identify a wider cohort of patients across the wider system.	Achieve Western Bay programme measures for admission avoidance Complete review of investment in intermediate care and CRTs to maximise return on investment		COO	PCS DU	Nurse Director PCS DU	USC Service Improvement Board	P&F Committee
	A28	Reinvest resources from anticipatory care planning into community nursing teams	Q2					This is part of the ABMU Winter Plan for 2018/19. ACP has been implemented across Clusters and Community Resource teams.	Reinvestment completed and technical efficiencies released (£0.5m)		COO	PCS DU	Nurse Director PCS DU	USC Service Improvement Board	P&F Committee
	A29	Review skill mix in community nursing and implement changes recommended by Cordis Bright and Capita	Q3-Q4					Actions ongoing	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 services established in each local authority area but variations in skill mix and resources available to each team. Consequently a funding bid submitted to Welsh Government against MH funds for 2017/18. Decision expected in August with plans to implement additional resources prepared. Investment already made and reduction in bed capacity as part of modernisation of OPMHS has resulted in reduction in admissions from 2016/17 to 2017/18.	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

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Unscheduled Care Service Improvement Plan Actions	A31	Implement joint Wales Ambulance Services NHS Trust (WAST) / Health Board initiatives outlined in Appendix 10	Q3					Work to continue to implement the joint work programme with WAST continues - as evidenced by a reduction in overall number of patients conveyed to hospital by an ambulance.	Reduce conveyances to hospital for non-acute the 'Big 5' conditions against the 2017/18 baseline.	Green (HCP) calls have reduced by 14% when compared to Q1 of last year. Amber calls have reduced by 8%.	COO		Asst COO	USC Service Improvement Board	P&F Committee
	A32	Implement revised falls pathway across the Health Board	Q1-Q4					I stumble version 2 has been developed by WAST and supported by the HB with a view to commencing implementation in care home settings in Q2. A business case to implement a falls vehicle within ABMU HB has been submitted to WAST for consideration. Consideration is also being given to potential opportunities to reduce patient falls conveyances to hospital as part of winter planning arrangements.	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					Work to expand the range of services provided on an ambulatory care is continuing. A business case is under development to support the provision of an ambulatory emergency assessment unit at PoW, approval has been given to support the development of the frailty service at Singleton and hot clinics are being progressed at Morriston. The acute clinical teams in the communities are also developing ambulatory models of care.	25% of acute medical admissions to be managed through an AEC pathway - measures in development.		COO		Asst COO	USC Service Improvement Board	P&F Committee
	A34	Implement changes to surgical unscheduled care pathways at POW within resources, eg 'chole quick', ENT pathways, trauma and gynaecology pathways.	Q1					Ambulatory Emergency Surgery - delivery of a second test of change for six weeks from 4th June 2018 resulting in a 42% reduction in Emergency General Surgery admissions and improvement in 4hr performance ranging between 2.63% and 5.39% daily (based on analysis of the first three weeks of data). A proposal for the permanent establishment of the AESU has been submitted as per the IGB process and is awaiting a decision regarding this being supported for implementation.	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					Measures agreed. Emergency Department • 1 hour response time for ED referrals • 4 hour urgent referrals Ward Based referrals • 24 hour urgent referrals • 72 hours ward routine referrals Swansea and NPT all stats are recorded on WPAS and currently being recorded and monitored (see current position) Model for provision of Psychiatric Liaison in POWH different to Swansea/NPT as linked to CRHT function which is an approach valued by General Hospital clinicians. Work underway in Bridgend to standardise data collection for whole Health Board picture to be presented and ensure outcomes are not different for different models. WPAS amended to enable collection of data and this has commenced in Swansea and NPT. Data analysis required to monitor adherence to targets as set out above for hours of operation of service as not 24 hour service. This will be available retrospectively next t Quarter for Swansea and NPT. Bridgend requires IT input to set up team electronically and train staff on WPAS changes before data can be collected.	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.	93% of patients seen within 24 hours at end Q1 compared to 82% at end 2017/18	COO	MHLD DU	IMTP Lead MHLD DU	USC Service Improvement Board	P&F Committee
	A36	Improve advance care planning for individuals who have advanced, progressive life limiting illness.	Q1					Macmillan-funded Advance Care Planning team in post	Optimise support for our patients and those important to them.		DoT		EoL Delivery Plan Lead	USC Service Improvement Board	P&F Committee
	A37	Implement ECIP plan within resources at Morriston	Q2					Emergency Care Improvement Plan- Q1 plan implemented with only one action being delayed in relation to the fast track #NOF pathway due to infection outbreak on the receiving ward area. Q2 - there has been some delay with the GP expected pathway flows however surgical specialties which makes up the greatest volume of patients within this group has now been implemented.	Contribution to achievement of HB target for 4 hour waits on site.	70.03% (Jun-18)	COO	MDU	SD, MDU	USC Service Improvement Board	P&F Committee
	A38	Implement ECIP plan within resources at POWH.	Q1					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. The actions and suggestions in that report are to be embedded in the Units unscheduled care and winter plans going forward. High turnover in leadership roles in the Unit has limited scope of the actions and priority has been given to those which potentially have the greatest impact or long term benefit.	Contribution to achievement of HB target for 4 hour waits on site.	82.64% (Jun-18)	COO	POW DU	SD, POW DU	USC Service Improvement Board	P&F Committee
	A39	Ensure Minors streams meets 4 hour standard.	Q4					Morriston Performance not broken down into Majors and Minors and classification of patient groups inconsistent with no nationally agreed definition. ENP fast track pathway implemented in Q1 which can be classified as a Minors stream within the ED, information requested to measure impact of the PDSA to review compliance with the 4 hour standard. Princess of Wales Hospital 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.	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 reconstituted USC delivery board. The Health Board is working towards the implementation of the discharge improvement plan developed in response to WAO discharge report. The Health Board is increasing communication and awareness of the impact of delayed discharge on patient outcomes (deconditioning). The Health Board is participating in and promoting the national #endpjparalysis campaign between April and July 2018, which was launched at Morriston hospital by the CNO in April. A full evaluation of the impact of this campaign will be reported to the USC board in August.	35% of patients discharged home before lunch. 100% of inpatients have an estimated Date of Discharge. Compliance with other metrics measured through the Patient Flow Workstream.	20.15% patients discharged before midday (Jun-18)	COO	All hospital units	Asst COO	USC Service Improvement Board	P&F Committee
	A41	Roll out TOCALS model to Singleton and POWH	Q1					Initial mapping underway. Senior Matron Sharron Price has linked with Jason Crowl as he is mapping similar pathways	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					Liaison prioritise referrals for AMAU (respond within 4 hours) 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 inreach support workers to work with identified patients and support them during their admission.	Improvement in compliance with same day assessment by psychiatric liaison team on 2017/18 baseline. Reduction in numbers of patients on general wards awaiting a MH bed.		COO	MHLD DU	MHLD SD	USC Service Improvement Board	P&F Committee
	A43	Implement comprehensive geriatric assessment for all patients >75 years (Quality Priority)	Q1					• Plans to enhance and develop frailty models within existing resources continue and include: o Accelerated placement team in NPT o Support for the development of the ICOP service in Singleton o Embedding and developing the redesigned frailty model at PoW o Enhancing the frailty model at Morriston through increased physio and social work support. The intermediate care consultants all proactively undertake CGA's. • Ongoing implementation of HB wide frailty models of care to support and promote improved patient outcomes and quality of care.	95% of patients over 75 years to have a CGA - measure sin development.		COO	All hospital units	Asst COO	USC Service Improvement Board	P&F Committee
	A44	Implement measures for the new Western Bay discharge standards.	Q2-4					Discharge standards now in place. New audit tool to assess against the standards is being evaluated.	Compliance with the measures		COO	All hospital units	Nurse Director PCS DU	USC Service Improvement Board	P&F Committee
	A45	Trial innovative ways to address deficits in domiciliary care and care home delays.	Q2					Additional support is being provided to enable improve discharge at an earlier stage to reduce the demand on domiciliary care.	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					SAFER floe bundle being rolled out and supported by Quality Improvement Team	Strategy Developed		DoT	All hospital units	Asst DoT	USC Service Improvement Board	P&F Committee
	A47	Develop early supported discharge rehabilitation model	Q2					ESD for COPD supported by IBG and being rolled out. ESD for stroke being developed as a joint proposal between Morriston and Singleton units. Discharge to Assess model also in development.	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					Detailed unit-based plans developed, public engagement closed 27th June. Staff consultation in place. Board recommendation is to implement changes in NPT and Singleton on a phased basis but to proceed with full changes in MH and Gorseinon.	Service remodelling schemes implemented in line with financial plan.		COO/DoS		Head of IMTP Dev	USC Service Improvement Board	P&F Committee

Actions and timescale									Impact Measurement		Responsibility and Accountability				
Corporate Priority	Action		Timescale	Progress				Quarterly commentary on progress	Measure	Current position where numerical measures	Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance
				Q1	Q2	Q3	Q4								
	A49	Implement new service models for Community Hospitals	Q2					Strengthened reablement focus, supported by PJ Paralysis. Service pathways at Gorseinon are being 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 on savings models.	Community Hospital models implemented in line with financial plan.		COO/DoHR	PCS DU	Nurse Director PCS DU	USC Service Improvement Board	P&F Committee
Stroke Service Improvement Plan Actions	A50	Confirm thrombectomy pathway for ABMUHB residents	Q1					Arrangements agreed locally in how we manage such patients but the commissioning of a new service is currently with WHSCC.	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					Ongoing campaign through patient televisions and other means	N/A		COO		Assoc Director R&S	USC Service Improvement Board	P&F Committee
	A52	Continue to develop TIA services	Q1-Q4					Improvements have been achieved in both units.	Access to TIA clinic within a number of days from referral (TBC)		COO		Assoc Director R&S	USC Service Improvement Board	P&F Committee
	A53	Capture patient reported outcomes through occupational therapy patient survey.	Q1-Q4					No information available	Increase in use of PROMS		DoN		Assoc Director R&S	USC Service Improvement Board	P&F Committee
	A54	Improve access to 'life after stroke' clinics.	Q3					No information available	Reduction in the number of bed days associated with patients on the stroke rehabilitation pathway against 2017/18 baseline.		COO		Assoc Director R&S	USC Service Improvement Board	P&F Committee
	A55	Refresh the business cases for ESD services and to assess opportunities to reinvest existing resources to improve services.	Q3					Business cases in the process of completion for consideration by IBG	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					Care Decision Tool is available for use for all palliative patients - difficult o measure specifically for stroke patients	Increase in number of patients who are managed in accordance with the All Wales Care Decision Tool against 2017/18 baseline.		DoT		EoL Delivery Plan Lead	USC Service Improvement Board	P&F Committee
Planned Care Service Improvement Plan Actions	A57	Roll out and develop use of E-Referrals.	Q1-Q4					98% of all electronic referrals from GP's are prioritised electronically with a view it will complete by October 2018. Functionality to support hospital > hospital referrals is in development by NWIS in readiness for local testing by ABMU to commence in Q2	All referrals submitted through e-referral route.	98% of e-referrals are prioritised electronically	COO/DoT		Asst Dir of Informatics	Planned Care Service Improvement Board	P&F Committee
	A58	Build whole system pathways	Q1-Q4					Work ongoing - Delivery Unit undertaken supportive work with POW and T & F groups being developed to take forward recommendations.	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					Funding agreed and recruitment of individual in place - hope to commence service in September.	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 Q3-4					National programmes delayed.	Initialise new Planned Care programme groups within the Health Board - working with the National programme roll out. Set up appropriate data sets to create base line and Develop models of Care consistent with National evidence. Develop a resilient and sustainable plan.		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee
	A61	Develop experience gained from current virtual clinics and share across other specialities.	Q1-4					Currently being taken forward in the Outpatient Improvement 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					Optometry and Nursing Review in Ophthalmology underway in Singleton and POW.	Continue with Audiology / Optometry / Therapies / Dentistry and extended Nurse Practitioners across range of services.		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee
	A63	Review New to follow up ratios	Q1-4					Good progress being achieved via the Outpatient modernisation Programme.	Ratios meeting national best practice	See O32	COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee
	A64	Develop clinical office sessions in job plans for key clinicians.	Q1-4					Delivery Units to implement as part of the Virtual clinic developments and impact.	Greater throughput and active monitoring rather than face to face contacts		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee
	A65	Develop Theatre Efficiency Board role in improving performance across sites.	Q1-4					Theatre Efficiency Board in place and meeting - with multidisciplinary teams. Efficiency and service improvement reviews underway and implemented as appropriate.	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.	Q1 Q2 Q3					Pre Assessment group in place and reviewing improvement. Workflow changes agreed and being implemented. SBAR discussion around centralising Pre Assessment for Swansea in Morriston.	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					Theatre Dash Board in place and additional efficiency indices being developed.	Look to introduce IT to improve selection / planning and communication between departments and theatre lists.		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee
	A68	Review areas where new equipment / technology could shift activity to Day Case or Outpatient procedure / other hospitals within ABMUHB not compromised for beds.	Q1-4					Solutions are being progressed in areas such as plastic surgery and orthopaedic hands to move day case activity out of theatres and into outpatient treatment sessions where it is clinically appropriate and evidence based.	Review current activity performed in Morriston that could be completed safely in Singleton. Review procedures that would be best performed as day case.		COO/DoT		Asst DoS	Planned Care Service Improvement Board	P&F Committee
	A69	Work with partner Health Boards to identify regional solutions to deliver routine elective surgery in protected capacity.	Q1-4					Discussions have taken place and a solution to locate a regional static staffed theatre unit at either the Morriston or Prince Phillip site to protect elective orthopaedic capacity has been investigated. However recent changes to the plans within Hywel Dda have put these discussions on hold.	Fewer cancelled procedures. Timely access and reduced RTT waiting times pressures.	62% reduction in number of elective procedures cancelled due to lack of beds (Jun-18 compared with Jun-17). 24% less patients waiting over 36 weeks for treatment (Jun-18 compared with Jun-17).	COO/DoT		Asst DoS	Planned Care Service Improvement Board	P&F Committee
	A70	Clear full year capacity plans in place to deliver agreed year end position.	Q1					RTT capacity plans are in place which delivers the health board year end profile of 2,664 for patients waiting over 36 weeks and Nil for patients waiting over 26 weeks for a first outpatient appointment. Delivery against the plans are monitored and challenged on a weekly basis.	Signed off plans in place. Resources agreed. Accountability letters issued.		COO COO/DoF COO-DoF		Asst DoS	Planned Care Service Improvement Board	P&F Committee
	A71	Implement inpatient patient surveys in cardiac services and ophthalmology.	Q2					No information available	Surveys in place		DoN		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee
	A72	Ensure that roll of F/U Priority Actions from planned care are sustainable.	Q1-4					Plans and actions in place for ENT, Ophthalmology, Urology and Orthopaedics.	Reduced backlog in FunB / appropriate and timely monitoring of patients.	9% increase in delayed follow-ups (Jun-18 compared with Jun-17).	COO / DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee
	A73	Roll out experience and best practice across other specialities to reduce FuNB pressures.	Q1-4					Outpatient Improvement group taking forward with units.	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

Actions and timescale									Impact Measurement		Responsibility and Accountability				
Corporate Priority	Action		Timescale	Progress				Quarterly commentary on progress	Measure	Current position where numerical measures	Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance
				Q1	Q2	Q3	Q4								
	A74	Identify appropriate IT solutions such as Amplitude / other PROM's based systems to assist monitoring and planning of reviews.	Q1-4					NWIS PROMs roll out being developed - concern around manual work around.	Continue roll out of PROM's systems. Support NWIS developments and identify alternative options such as in Ophthalmology.		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee
	A75	Review Discharging arrangements to safely discharge patients / and facilitate See on symptom arrangements.	Q1-4					No information available	Discharge arrangements reviewed and plan implemented. See on Symptom arrangements in place. Ensure Primary Care services involved and aware. Ensure Primary Care services involved and aware.		COO/DoT		Assoc Director of R&S	Planned Care Service Improvement Board	P&F Committee
	A76	To support symptom awareness campaigns, collaborate with Primary Care to make available risk assessment tools, training materials and provide access to specialist support.	Q2					Public Health released The All- Wales Annual Report, Screening Division on 17th January 2018, presenting 2016/17 data. Key messages include:- • A successful pilot using HPV primary testing in 20% of GP practices in Wales has been running since April 2017. This is informing the implementation of HPV testing as the primary cervical screening test, with full roll-out planned in October 2018.• Planning is underway for the implementation of FIT (Faecal immunochemical testing) as the primary test in bowel screening, with a phased implementation due to start in January 2019.• An eleventh mobile breast screening unit became operational which has improved resilience in Breast Test Wales and helped support work to reach and maintain the 36 month round length.• Uptake for screening mammography remains steady. Wales exceeds the minimum standard of 70%. Uptake for ABMU is reported as 73.5%. Uptake of bowel screening does not meet the 60% target in Wales (53.4%). Uptake has fallen this year by 1%, though this is on the background of an almost 4% rise the year before, so there is still an overall upwards trend over the last few years. Uptake for ABMU is reported as 53.2%. Coverage of Cervical Screening across Wales is still close to the target of 80% at 77%, meaning that nearly eight out of ten women in Wales have been screened in the last five years. However, this year again there has been a slight drop, in line with the trend seen in other countries. Uptake for ABMU is reported as 76.1%	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.	Mammography screening reported as 73.5% uptake compared to Wales average of 70%. Bowel screening is the same as the Wales average at 53%. Cervical screening is similar to the Welsh average (77%) at 76.1%.	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					Singleton Delivery Unit have requested the support of the Cancer Improvement Team to undertake Demand & Capacity modelling for endoscopy across Swansea and Neath. Work for this has been undertaken and now requires the validation with the Service Group team before progressing further.			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					Whilst work has been undertaken and is being undertaken to understand demand and capacity and lead times along components of a pathway, i.e. Breast OPA, radiology; radiotherapy and chemotherapy, component waits for an individual patient by tumour site have not yet been worked through, however they remain planned for the next phase of the ABM Cancer Dashboard. This phase of work will commence in July, the completion date is dependent on the successful implementation of other cancer related dashboards. The Demand & Capacity project within ABM University Health Board is being undertaken as part of a joint working programme between Informatics, Cancer Information and the Cancer Improvement team. The programme is concentrating on allowing the service managers to visualise their live demand, activity and current queue (Work In Progress) at each component part of the Single Cancer Pathway (SCP). A demonstration of the work undertaken to date was presented at the National SCP workshop on the 26th June 2018. Programme Aim: To develop a 'live dashboard' on which we can monitor our weekly Urgent Suspected Cancer (USC) 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) at each component part of the pathway. The new Vitals chart section allows us to predict future lead times (referral received to patient first seen) and monitor them against the target maximum lead-time of two-weeks. This system will provide a real time feedback loop that will allow the service managers to monitor the USC Breast, Gastroenterology, Urology, Whilst work has been undertaken and is being undertaken to understand demand and capacity and lead times along components of 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.	32% of patients have their first appointment at 14 calendar days or less.	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					RDC moved to 2 sessions a week and since December 2017 has covered 6 clusters – Neath, Upper Valleys, then Bridgend North added and then 3 Swansea clusters. Macmillan Clinical Nurse Specialist in post – improved HNA and dialogue with primary care. Continue to see a steady increase in referrals, and increasing numbers of cancer and serious non-cancer diagnoses. April 2018 saw the start of a project, working with Swansea University, to undertake an interim evaluation, RDC team were able to gain £25K CRUK funding for this work, aiming to report this to ABMUHB July/August 2018. Scoping exercise underway to look at a possible role for patients presenting at ED/AGPU that would be better served within the RDC. Continue to look at skill mix to improve efficiency.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	A80	Increase sustainable outpatient capacity for USC patients.	Q1					Demand and capacity modelling work being undertaken in Breast, Gynaecology, Urology, Gastroenterology and Lower GI.			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					A 'One stop' clinic has been established at NPTH from 1st May 2018 which will significantly reduce the time to first outpatient /diagnostic. Live demand and capacity modelling has been provided to the Unit via the Cancer Dashboard and demonstrated the USC capacity required to meet demand and maintain timely activity throughout the year on both Singleton and Neath Port Talbot sites. This can be used to prospectively predict the lead time for patients in the queue by dividing the size of the Queue (WIP) by the Average number of weekly slots available (Little's Law) providing the queue is relatively stable.			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					Unit Medical Director to meet with Clinical lead to review the Prostate pathway. Demand and Capacity modelling work has been undertaken for Urology OPA waits with waits to test including cystoscopy, biopsy etc. Being worked on currently by the Cancer Improvement Team to provide the POWH Unit with robust data for longer term service planning.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	A83	Revise Post-Menopausal Bleeding pathway.	Q2					Revised PMB pathway implemented – clinics being delivered 3 days a week – job plans need to be finalised to ensure resilience of a 5 day service.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	A84	Deliver revised Post-Menopausal Bleeding pathway.	Q2					Revised PMB pathway implemented.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	A85	MyoSure activity to be introduced to Singleton and Neath	Q3					One-stop diagnostic model for postmenopausal bleeding and pelvic masses implemented			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	A86	Cancer improvement Board to focus on immediate performance issues as well as sustainable improvement breast, gynaecology and urology.	Q1					Cancer Improvement Board established and Terms of Reference agreed. Meetings are held on a monthly basis			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	A87	Support and Challenge Panels to evolve to ensure constructive challenge; update and support to each MDT.	Q1					Support and Challenge panels have been held with 5 MDT Leads since March (Pancreatic, Sarcoma, LGI – PoW, Lung- PoW and Urology – Swansea).			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 for Quarter 1 developed and reviewed at the May Cancer Improvement Board			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	A89	Recommendations following the MDT review to be implemented and audited.	Q2					Recommendations from MDT assessments discussed at the Support & Challenge Panels with follow up review planned for 6 months later.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee

Actions and timescale								Impact Measurement		Responsibility and Accountability				
Corporate Priority	Action		Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures	Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance
Cancer Service Improvement Plan Actions	A90	Implementation of revised MDT Operational policy and MDT Co-ordinator job description.`	Q1					Revised MDT Operational Policy implemented in January 2018. Revised MDT Co-ordinator job description implemented at PoW. Implementation at Singleton remains incomplete.	As line 93		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					Interviews for a Cancer Quality Improvement Manager to be held on August 7th 2018. The post holder will play a key role in leading and delivering the Cancer Services Improvement Programme across ABMU Health Board as part of a core team driving the pace and scale of transformation using the principals of Prudent Healthcare through a Value Based Healthcare approach. Working with the Health Board's Strategic Planning teams in applying a Value Based Healthcare approach to a regional pathway, starting with Lung Cancer.			COO/DoS		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	A92	Clear plans to deliver compliance with the single suspected cancer pathway by April 2019.	Q4					The Health Board has established a Single Cancer Pathway implementation Group to lead on the preparation for the implementation of the Single Cancer Pathway by April 2019. The Group will advise on process, guidance on monitoring and reporting and mechanisms for the collection of data. On the 3rd July 2018, 1000 Lives facilitated a SCP Workshop for Managers and MDT's to support our communication and engagement with clinical leads and managers and the wider MDT, this was well attended. Areas for support and development were identified and further discussions with MDT's will be taken forward. SCP Project Support appointed for 1yr from the monies allocated from WCN. ABMU have been 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. An implementation plan has been drafted and will continue to be refined as the work streams progress, National Optimal Pathways agreed and information solutions identified.			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					WCN have appointed a Project Manager who will lead on this initiative with the aim to drive forward this work and enable a collaborate approach across all the relevant areas. HB Cancer Executive Lead, Cancer Lead Clinician and Cancer Quality & Standards Manager met with the Project Manager on 8th June 2018			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	A94	Implement Non-Surgical Cancer Strategy	Q1-4					In progress			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					Gynaecology Report received and action plan developed. Acute Oncology Services and Breast services are awaiting their outcome reports. Thyroid self-assessment currently being undertaken. 2nd Skin Peer Review scheduled for September 2018. MS& MB have met with Sam Williams to discuss the Childrens Peer Review scheduled for November. MS has met with Ann Benton (TYA Lead) 2/7/18 to discuss TYA Peer Review scheduled for November. Sarcoma and Cancer Pathway Peer Reviews scheduled for December 2018			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 PROMs collection live in Morriston Hospital Lung Cancer clinic. National review on-going re post intervention collection. Discussions initiated with Singleton & Neath to initiate baseline collection.			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 Plan updates requested in June 2018 for review by the Cancer Quality & Standards Manager			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	A98	Increased focus on Gynaecology theatre booking and utilisation.	Q1					Ad hoc sessions only possible when there are suitable patients – currently being delivered due to goodwill of surgeon – impacting on OPD			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					Service are participating fully in the HB commissioned review (ICHOM)of the lung cancer pathway and its impact on thoracic surgery and implement agreed actions					Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	A100	Review of pathways and implementation of improvements.	Q1-4					Work being undertaken by CSCG's to develop National Optimal pathways. Lung and colorectal pathways agreed.			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					Acute Oncology Peer Review Visit undertaken on the 10th July 2018, awaiting outcome report. CNS and administrative staff appointed in Pow. Advert for Clinical Lead closed 30th April 2018.No applicants. Discussed with Medical Director and agreed to discuss other options with Macmillan to include commissioning support from Palliative Care consultants. Also discussions with Cwm Taf			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					Macmillan Cancer Strategic Transformation Lead Nurse appointed on July 5th and Macmillan Person Centred Care Manager appointed on July 9th 2018. Start dates not confirmed yet.			COO		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
	A103	Appointment of HB Cancer Strategic Transformation Lead Nurse.	Q1					As above	Measure patient satisfaction through Patient Satisfaction Surveys Reduced complaints Audit		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					As above			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					As above			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					As above			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					Quarterly meetings commencing from July between Dr Jenny Brick (Macmillan GP facilitator), Macmillan AHP, Macmillan Primary Care Cancer Lead Nurse and Cancer Quality & Standards manager			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						Compliance against the Cancer Information Framework. Audit outcomes.		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					Live demand and capacity modelling has been provided to the Breast Unit and PMB via the Cancer Dashboard. Urology OPA, Gastroenterology and LGI general surgery planned to go live week commencing 25th June 2018. Planning to go live with the NUSC dashboard week commencing July 16th 2018. Work is being undertaken to bring radiotherapy waiting times information and gynaecology OPA view into dashboard. A calculator has also been developed to allow services to simulate the effect additional capacity may have on waiting times of patients in the queue and predict how long it will take to clear backlog and sustain a 10 day wait to first outpatient or to work out how much capacity is required to deliver a 10 day wait in the shortest timeframe.			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					Cancer Information Manager attending NWIS meeting on July 19th 2018			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								DoNQ		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee

Actions and timescale									Impact Measurement		Responsibility and Accountability				
Corporate Priority	Action		Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures	Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance
	A112	Cancer Audit participation.	Q1-Q4					National Breast Audit (NABCOP) submitted July 2018			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					The portfolio of research trials available in the Cancer Centre remains strong. Surgical cancer trials are successfully recruiting to target. There is also an increase in planned radiotherapy trials due to open in the next quarter. The Research Strategy for radiotherapy has been launched and regular radiotherapy research working group meetings have been established quarterly. 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			MD		Quality and Standards Manager - Cancer	Cancer Service Improvement Board	P&F Committee
HCAI Service Improvement Plan Actions	A114	Clinician audits to identify reasons for high usage and recommend and implement audit actions.	Q1					No regular clinician audits at present. Clinician audits of antibiotic prescribing have been undertaken in Singleton and POWH, but these have not specifically focussed on areas with high usage of antibiotics Paper to go to ABMU Antimicrobial Stewardship Group suggesting change from pharmacist-led bimonthly audits to clinician-led monthly audits against SSTF, using Public Health Wales audit tool. Audits will be done in all areas, as per current audit programme.	% reduction in total antibiotic usage volumes across the Health Board (primary care to improve on 2017/18 baseline; 5% reduction in secondary care.	Data from primary care in the 6 months to May 2018 shows a 2% increase in total antibiotic prescribing compared with the equivalent period in 2017; (this may reflect the impact of the increase in influenza activity last season).	DPH		Lead Nurse - IPC	Infection Control Committee	Quality and Safety Committee
	A115	Isolate patients with unexplained diarrhoea within 2 hours of symptom onset.	Q1					Lack of isolation facilities impact on the ability to achieve this	40% patients with unexplained diarrhoea isolated within 2 hours of symptom onset; 100% within 24 hours.	Available data for *Clostridium difficile* infection shows 44% of patients isolated within 2 hours; 25% had not been isolated 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					There is variable compliance with achieving this between service delivery units. In some units, requests not regularly made for deep cleaning because there are not adequate decant facilities to enable this. Throughput and bed occupancy impact on the ability to achieve this. There is better compliance with deep cleaning of single rooms. UVC and HPV is still not available for use.	% 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 available and promoted. The use is checked by ICNs on their assurance visits to wards and departments.	% compliance with algorithms	Available data shows that 68% of patients were treated according to the treatment algorithms.	DPH		Lead Nurse - IPC	Infection Control Committee	Quality and Safety Committee
	A118	Baseline audit of PVC incidence in Delivery Units. Reinvigorate STOP campaign. Adhere to best practice guidance for insertion, maintenance and removal of PVC's.	Q2					Information on PVC incidence collected in pilot wards at Morriston; this is to be rolled to the remainder of the delivery unit. Also to other delivery units. This to be used as a basis for promotion of removal of unnecessary devices. Use of bundles monitored via Care Metrics: Metrics shows 61 - 75% compliance with PVC insertion bundle; 76 - 89% compliance with PVC maintenance bundle. Data being reported for each Delivery Unit by hospital acquired cases and community acquired cases as identified through localised surveillance.	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).	Delivery Units have not achieved a 10% reduction in Staph. aureus bacteraemias the ; this reflects the overall Health Board position (13% more cases of Staph. aureus bacteraemia than the equivalent period in 2017/18).	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					Information not recorded on Care Metrics at present. DoPs assessors in all delivery units; Staff have been competence assessed in every delivery unit.	% 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).	There are 208 DoPs assessors in the Health Board. There are 635 staff who have been assessed by DoP in the Health Board	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					Not implemented to date. To be discussed at ICC. Compliance continues to be assessed and reported by ward/department on Metrics.	95% hand hygiene compliance.	Metrics show hand hygiene compliance 94-95% (April - June)	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 not undertaken to date.	% 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 on revised decolonisation almost complete. New policy to be launched when complete and pharmacy staff confirm that products are ordered/available.			DPH		Lead Nurse - IPC	Infection Control Committee	Quality and Safety Committee
	A123	Baseline audit of urethral catheter incidence in Delivery Units. Reinvigorate STOP campaign. Adhere to best practice guidance for insertion, maintenance and removal of urethral catheters.	Q1					Information on urethral catheter incidence collected in pilot wards at Morriston; this is to be rolled to the remainder of the delivery unit. Also to other delivery units. This to be used as a basis for promotion of removal of unnecessary catheters. Use of bundles monitored via Care Metrics. Metrics shows 84 - 91% compliance with urethral catheter insertion bundle; 77 - 89% compliance with urethral catheter maintenance bundle. Data being reported for each Delivery Unit by hospital acquired cases and community acquired cases as identified through localised surveillance.	5% reduction in patients with E.coli bacteraemia; data to be reported for each Delivery Unit by hospital acquired cases and community acquired cases (as identified through localised surveillance).	5% fewer cases of E.coli bacteraemia than the equivalent period 2017/18 (Health Board). Morriston DU and Singleton DU have achieved a greater than 5% reduction in E.coli bacteraemia compared the equivalent period in 2017/18)	DPH/DoN		Lead Nurse - IPC	Infection Control Committee	Quality and Safety Committee
	A124	Hand hygiene actions as above.	Q1					Peer hand hygiene audits not implemented to date. Compliance continues to be assessed and reported by ward/department on Metrics.	Hand hygiene measures as above.	Metrics shows hand hygiene compliance 94-95% (April - June)	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 awaiting ratification - the use of the catheter passport is included in the policy. Blocked catheter pathway has been included in the catheterisation policy which is to be ratified soon.	% 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				
	D12	Rare Diseases Delivery Plan	Q4								DoT				
	D13	Respiratory Health Delivery Plan	Q4								COO				
	D14	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)						
	M29	**LoS**	Q1-4					There is evidence of improvement in LoS at Neath Port Talbot hospital and a slight improvement in Singleton.	Improvement compared to Welsh peers		COO	All DUs	Head of SLR and external contracting	P&F Committee	Board
	M30	**Theatre efficiency**	Q1-4					Actions ongoing	Achieve 90%	91% achieved at Morriston at end Q1	COO	Hospital DUs	Head of Information	P&F Committee	Board

Actions and timescale									Impact Measurement		Responsibility and Accountability				
Corporate Priority	Action		Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures	Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance
Demonstrating Value and Sustainability Objective Measures	M31	**New Ops - DNAs**	Q1-4					In 2017/18 there were a total of 60,912 (18,406 New; 42,506 Follow Up). The Health Board Annual Plan 2018/19 has identified a target of 10% reduction in New Outpatient DNAs for 2018/19. The Outpatient Improvement Group has also applied this target to Follow Up DNAs. The Delivery Units have prioritised specialties (new and follow up) and produced associated action plans to improve their position. These are being monitored and supported via the Health Board Outpatient Improvement Group, reporting into the Planned Care Supporting Delivery Board. At the end of June 2018 on a Health Board wide basis, the target DNA rate of 6.2% for New Outpatient appointments has very nearly been achieved (6.4%), the target DNA rate of 8% for Follow Up appointments having been achieved.	Achieve 10% reduction on 2017/18 eoy baseline	1.2% reduction (Jun-18= 6.2%, Jun 17= 7.4%	COO	All DUs	Service Improvement Manager, NPT	P&F Committee	Board
	M32	**New Ops - referrals**	Q1-4					The Annual Plan 2018/19 has 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, supported by the Outpatient Improvement Project Manager, to move to 100% compliance with use of e-referral. The Outpatient Improvement Group will also build on the work undertaken through the Planned Care Programme to replicate the approach taken with audiologists and optometrists being utilised to reduce the pressure on secondary care services and provide better access for patients in the community setting. The 1% reduction in referrals target equates to 28,060 referrals per month. To the end of June 2018, performance is slightly below against target.	Achieve 1% reduction on 2017/18 eoy baseline	2% reduction (Jun-18= 7.4%, Jun-17 =9.4%)	COO	All Dues	Service Improvement Manager, NPT	P&F Committee	Board
	M33	**New: Follow-up ratios**	Q1-4					Actions ongoing	Improvement compared to CHKS peers		COO	All Dues	Service Improvement Manager, NPT	P&F Committee	Board
	M34	**Redesign Service pathways using VBHc approach**	Q4					On track. Diabetes business case going to IBG Oct. COPD currently in recruitment stage.	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					iCOP model in place at Singleton and recruitment on track to fully staff. New frailty model developed between Morriston and Gorseinon. Surgical remodelling ongoing at Morriston. Business case for Frailty at the Front Door for POWH going to IBG in August. Maesteg Day Hospital model being reviewed. Investment of £1.6m in OPMH complete, Board recommendation to proceed with inpatient capacity closures. Frailty Model being developed, review of Older People's programme structures underway.	N/A		DoS	Service Remodelling Workstream	Head of IMTP Dev	P&F Committee	Board
Corporate Objective 4 - Securing a Fully Engaged and Skilled Workforce															
		Achievement of Workforce Indicators:													
	M36	**Reduction in vacancy rate**						We continue to engage nurses from outside the UK to help mitigate the UK shortage of registered nurses. To date we have in our employ: • EU Nurses employed at Band 5 = 70 • Philippine nurses arrived in 17/18 and employed at Band 5 = 28 We are also currently exploring further options of nurses from Dubai and India. We are in the process of preparing a mini tendering exercise which will be aimed at suppliers who are able to provide overseas qualified nurses who already have the requisite English language requirements as this has been the time delay to date in our recruitment timeline. In addition, we are taking actions to develop / grow our own Nursing workforce. These include: • Regionally organised nurse recruitment days which ensure we are not duplicating efforts across our hospital sites. These are heavily advertised across social media platforms via our communications team. • Eleven of our Health Care Support Workers (HCSW's) recruited to a part time degree in nursing. Seven commenced in September 2017 on a four-year programme, the remainder commenced in January 2018 on a two year nine month programme. We have also secured further external funding to offer similar places to Thirteen HCSW's in 18/19 and recruitment to these places is underway. • A further thirteen of our HCSW's have also been successful in gaining places on 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.	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**						• Since the end Mar 18 the rolling 12 month turnover rate has reduced from 9% to 8.6% and has reduced by almost 1% over the last 12 months. • The number of staff leaving within the first 12 months of start date has reduced by 78 in the last 12 months from 431 to 353. • Exit interview process piloted within Nursing and Midwifery for staff leaving within 12 months of start date. Data from this will allow us to identify any themes for action in this difficult to recruit staff group. • The exit questionnaire module within ESR has now been activated for all staff which will allow us to identify themes which require addressing from the data collected.	Reduce from eoy 2017/18 baseline	Since the end Mar 18 the rolling 12 month turnover rate has reduced from 9% to 8.6% and has reduced by almost 1% over the last 12 months.	DoHR		Asst DoHR	P&F Committee	Board
Securing and Fully Engaged and Skilled Workforce Objective Measures	M38	**Reduce sickness absence**	Q1-4					• Sickness absence - The 12 month rolling performance to the end of May 18 is 5.79% and represents an overall decline in performance of 0.02% since the beginning of 2018/19. • Standardised process and methodology for LTS scrutiny being piloted. • Currently developing LTS pathways to help guide managers in managing common absence conditions. • Best practise case study being conducted in three areas of good sickness performance to share good practise. •Bespoke sickness actions developed based on individual feedback from units into how to improve sickness absence. •Text reminder service for OH appointments to reduce DNA now in use •Mental health awareness training provided for 48 managers over six sessions •Work related stress risk assessment -78 managers trained over eight session •Appropriate OH referrals training-83 managers trained over 4 sessions. • 180 Wellbeing Champions trained to provide signposting to early intervention/support for staff.	Reduce by 5% on 2017/18 eoy baseline	The 12 month rolling performance to the end of May 18 is 5.79% and represents an overall decline in performance of 0.02% since the beginning of 2018/19.	DoHR		Asst DoHR	P&F Committee	Board
	M39	**Improve PADR compliance**						• Continuation of PADR Training for Mangers with specific requested sessions being delivered at POW Site • increase in compliance from April 2017 54% • Mental Health and Learning Disabilities 79.02% and Primary and Community Care 78.85% • Morriston SDU 59.63%, Singleton 59.23% and Princess of Wales 58.12% compliance. • Highest corporate department compliance is Finance 70.97% • Lowest corporate department compliance is Informatics and ICT 21.64%	Achieve 85% target	63% (Jun-18)	DoHR		Asst DoHR	P&F Committee	Board
	M40	**Improve mandatory and statutory training compliance**						• Review and rewrite of the ESR guide for accessing and completing Mandatory and Statutory Training- Publication on the staff intranet • Workshop held with representatives from ABMU, NWIS and Shared Services to look at the best way to use systems across ABMU including M+S E-learning access • E-Learning drop in sessions have been delivered across all major sites allowing individuals to highlight any issues and complete training, • Individuals who have experienced systematic issues have had their compliance updated manually	Achieve 85% target	57% (Jun-18)	DoHR		Asst DoHR	P&F Committee	Board
	M41	**Reduce variable pay**						The recommendations of the exercise to use the MONITOR agency tool has been circulated to DUs for comment. Subject to comments received the recommendations will be implemented in Q2/3. Work continues on the roster efficiency programme aligned with the plans for standardising nurse shift patterns within each Delivery Unit, this work which will help optimise staff utilisation and reduce variable pay is being progressively rolled out cross the HB. The feedback from the implementation of new bank software linked to rostering has been positive, allowing the bank function to be able to respond to increases requests for bank usage but holding fill rates at high levels.	Reduce by 10% from eoy 2017/18 baseline		DoHR		Asst DoHR	P&F Committee	Board

Actions and timescale									Impact Measurement		Responsibility and Accountability				
Corporate Priority	Action		Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures	Exec Lead	Delivery lead - mechanism	Monitoring lead	Reporting and monitoring	Board Governance
	M42	**Workforce and OD Strategy in place**	Q4					The development of a W&OD Strategy for ABMU must be aligned to, reflect and support the delivery of the HBs overarching organisational Strategy and Clinical Services Plan. Work on these are currently in development and will be drafted during the summer and autumn of 2018. Following the development of these overarching plans it will then be possible to produce the W&OD Strategy which will both reflect and support the direction of travel and delivery. The production of a W&OD Strategy in the absence of an Organisational Strategy is not the most appropriate approach.	Strategy in place		DoHR		Asst DoHR	P&F Committee	Board
	M43	**Improvement in staff engagement**	Q4					Significant public and patient involvement during our NHS@70 celebration campaign. This commenced in February and will run throughout 2018. Celebrations include publication of a NHS@70 memory book, symbolic lamp relay across the geography of ABMU, music festival and tea parties and Chairman's VIP Staff Awards scheduled for July 2018. Valuing the diversity of roles in the Health Board was also recognised during a high profile '70 faces' campaign. The team were inundated with requests to take part in this and the result is a lasting legacy of images and comments celebrating what NHS means to individuals and teams. A combined Patient Choice Award and Long Service Awards was held in Morriston in May 2018 and recognised the contribution of more than 30 individuals and teams across 10 award categories. The ceremony was hosted by Non officers Tom Crick and Maggie Berry and an ABMU apprentice sang at the awards. A comprehensive programme of staff listening took place with Estates staff from February 2018 through to July 2018 in response to previous survey results. Eighteen listening sessions took place across all sites and involving all staff to identify 'what needs to change'. Actions are now being implemented and led by the Senior Leadership Team in Estates. Team development and behavioural leadership development for the senior team will also follow. The NHS Staff Survey was launched in June 2018 and completion continues to be actively promoted using a range of different methods, including an extensive social media presence, promotional stands in hospitals and walking the wards and corridors using iPads. The results of this survey will be available in October 2018.	Staff survey (against 2017/18 baseline)		DoHR		Asst DoHR	P&F Committee	Board
Unscheduled Care Service Improvement Plan Actions	A126	Implement the local and Health Board wide programme of workforce redesign for Unscheduled Care.	Q1-Q4					Ongoing	Achievement of Workforce Improvement Indicators. Achievement of actions outlined above.		COO/DoHR		Asst COO	USC Service Improvement Board	P&F Committee
Stroke Service Improvement Plan Actions	A127	Explore opportunities to expand targeted 7 day cover through workforce redesign	Q1-4					Ongoing	Increase the number of generic roles.		DoHR		Assoc Dir R&S	USC Service Improvement Board	P&F Committee
	A128	Recruitment to 2nd SPR in Morriston to support 4 hour bundle.	Q2					9 additional senior posts appointed and will be in place in August 18.	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					Staff training programmes being developed / in place	Evidence of staff who have received stroke training awareness sessions.		DoHR		Assoc Dir R&S	USC Service Improvement Board	P&F Committee
	A130	Continue training and awareness in communication skills and advance care planning.	Q1-Q4					In progress	Improve End of Life Care		DoT		Assoc Dir R&S	USC Service Improvement Board	P&F Committee
HCAI Service Improvement Plan Actions	A131	Review funding allocation for DU rapid Response Teams to undertake the cleaning and decontamination of all equipment and environments, releasing nurses' time for patient care activities.	Q2					Bid made for funding to enable this transfer of role/service. No progress made.	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	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 has recently set up training for community staff which includes catheter care at home. The training has been extended to care home staff. Catheter care is also supported by the adoption of the Catheter passport.	Models reviewed.		DoN	IPC Team	Head of Nursing, IPC	Infection Control Committee	Q&S Committee
	A134	Antimicrobial stewardship training across the Health Board.	Q1					Antimicrobial stewardship training sessions provided on junior doctor induction by antimicrobial pharmacists; other sessions provided when requested.	Training rolled out.		DoN	IPC Team	Head of Nursing, IPC	Infection Control Committee	Q&S Committee
	A135	Consider alternative models for antimicrobial review in relation to the Focus element of "start Smart, Then Focus", e.g. nurse/pharmacist prescribers.	Q2					Completion of 48-72 hour review section is audited bimonthly at present. Alternative models for antimicrobial review have not been considered to date. Paper to go to ABMU Antimicrobial Stewardship Group suggesting change from pharmacist-led bimonthly audits to clinician-led monthly audits against SSTF, using Public Health Wales audit tool. Audits will be done in all areas, as per current audit programme.	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					There is significant slippage in the delivery of the agreed savings programme. Mitigating actions are being deployed to offset the non delivery of savings. R&S Programme are monitoring the position on a monthly basis and individual issues have been escalated to PFC as required.	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					The HB has a planned forecast deficit of £25m. The focus for the HB is the delivery of and improvement on the current £25m forecast.	Financial control total		DoF		Asst DoF		P&F Committee
	M46	**Enabling and supporting plans delivering required improvements (to achieve financial control total)**	Q1-4					The HB are continuing to develop and fully implement plans to support delivery of the forecast financial position.	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					Discussions have taken place and a solution to locate a regional static staffed theatre unit at either the Morriston or Prince Phillip site to protect elective orthopaedic capacity has been investigated. Recent changes to the plans within Hywel Dda have put these discussions on hold.	Contracts in place Commission of activity underway.		COO		Asst DoS	JRPDC	Board
	A137	Agreed LTA in place for both organisations as a commissioner.	Q1					LTAs signed within the Welsh Government deadline.	Signed agreed documents		DoS/DoF		Asst DoS	JRPDC	Board
	A138	Agree models of service where workforce can be shared.	Q2					In progress	Consultants and other staff working across boundaries.		DoS/COO		Asst DoS	JRPDC	Board
	A139	Agree repatriation pathways in place for key pressured services, vascular, cardiology (unscheduled care benefits also)	Q2					In progress	Signed off pathways in place and operational		COO		Asst DoS	JRPDC	Board