Meeting Date	**31st May 2018**	**Agenda Item**	**2i.**
Report Title	**End of Year Report on the Implementation of the Annual Plan 2017/18**		
Report Author	Nicola Johnson, Head of IMTP Development and Implementation		
Report Sponsor	Siân Harrop-Griffiths, Director of Strategy		
Presented by	Siân Harrop-Griffiths, Director of Strategy		
Freedom of Information	Open		
Purpose of the Report	The report provides the Board with an end of year report on the implementation of the Annual Plan 2017/18.		
Key Issues	The report is a covering report for the detailed monitoring of the 109 actions which were included in the Annual Plan 2017/18. The actions directly support the delivery of the Corporate Objectives which were laid out in the Plan and the achievement of the actions linked to each Objective heading is shown. The report also indicates that the link between achievement of the actions and performance improvement is variable. More detail on this is explained in the full Health Board Performance Report. The report will be considered by the Performance and Finance Committee for assurance before the Health Board meeting. Once approved the report will be shared with Welsh Government for assurance purposes.		

Specific Action Required ***(please ✓one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
				✓

Recommendations	The Board is asked to: - • **Endorse** the final year report on the implementation of the Annual Plan 2017/18; and, • **Approve** the assessment for sharing with Welsh Government.

END OF YEAR REPORT ON THE IMPLEMENTATION OF THE ANNUAL PLAN 2017/18

1.0 Introduction

The purpose of this report is to provide the Board with a final update on the implementation of the actions set out within the Annual Plan 2017/18 as at the end of Quarter 4.

This report is not intended to be a reflection of the performance delivery of the Annual Plan as this is subject to more detailed in commentary in the main Health Board performance report. However a very brief commentary is provided on performance metrics as this provides important context to the implementation.

2.0 Background

The Annual Plan implementation monitoring report for Quarter 4 is attached at **Appendix A** for the Board's consideration. **Appendix A** is the detailed internal monitoring return and the narrative explanation and summary commentary which follows in section 3.0, is now included for ease of reference in this covering paper.

This report should be considered in tandem with the main Health Board performance report.

3.0 Assessment

3.1 Overall Assessment of Achievement

All of the required detail is contained within **Appendix A** which tracks all of the actions, timescales and progress of the actions set out in the Annual Plan 2017/18. The report is structured by each Corporate Objective which link directly to the Annual Plan document itself and in the heading of each Corporate Objective is colour coded as follows:

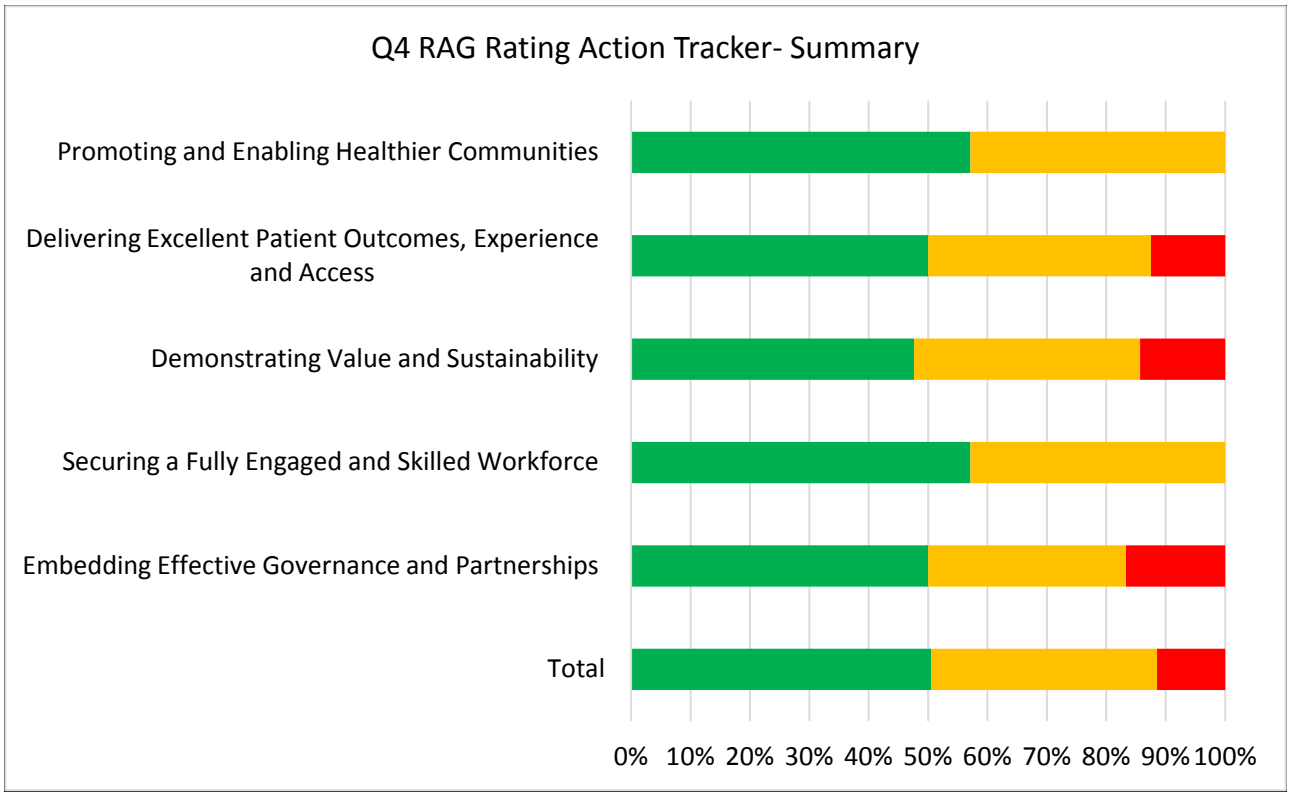
Promoting and Enabling Healthier Communities
Delivering Excellent Patient Outcomes, Experience and Access
Demonstrating Value and Sustainability
Securing a Fully Engaged and Skilled Workforce
Embedding Effective Governance and Partnerships

The monitoring return is laid out by Corporate Objective but within each Objective the actions are grouped by the seven National Delivery Framework domains to enable cross referencing and consistency with the Integrated Performance and Quality Report.

Performance is assessed on a Red/Amber/Green (RAG) system and is summarised at the start of the report by Corporate Objective. There were 109 actions in the Annual Plan 2017/18 and 53 of the actions have been completed demonstrating 49%

of actions completed. Of the remaining actions, 37% are still in progress and 11% are closed, on hold or not progressing. An explanation of the position of the red marked schemes is included below.

The overall summary of achievement is set out in the figure below.



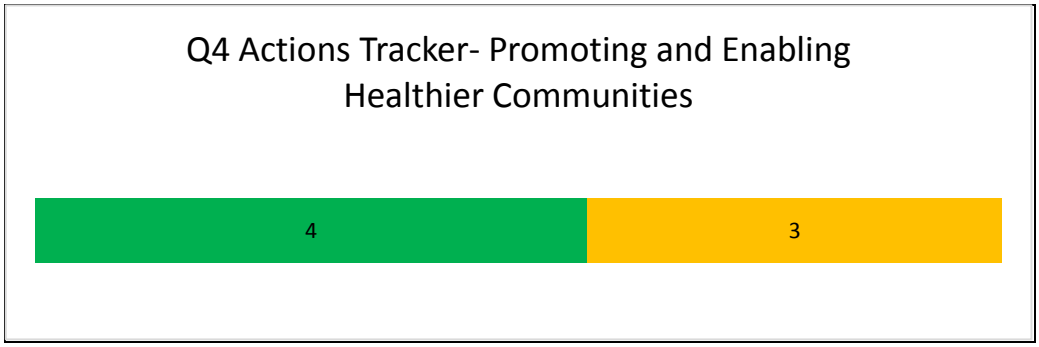
The table below sets out the number of actions supporting the delivery of each objective and the RAG position.

	Green	Amber	Red
Promoting and Enabling Healthier Communities	4	3	0
Delivering Excellent Patient Outcomes, Experience and Access	32	24	8
Demonstrating Value and Sustainability	10	8	3
Securing a Fully Engaged and Skilled Workforce	4	3	0
Embedding Effective Governance and Partnerships	3	2	1
Total	**53**	**40**	**12**

The proportion of completed (Green) actions has increased to 49% at the end of the year from 25% in Quarter 3. The number of off track (Red) schemes has increased by 1% in the quarter. The impact of the actions remains variable and this is shown in more detail in **Appendix A** and is aligned to the main Health Board performance report.

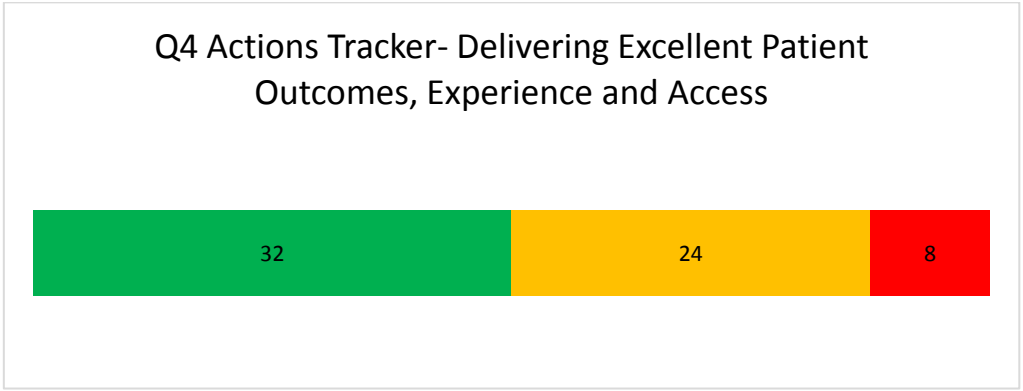
3.2 Summary of Achievements by Corporate Objective

Corporate Objective 1 - Promoting and Enabling Healthier Communities



The Children and Young People's Strategy was approved by the Board in September 2017 and an implementation plan is in development. The Health Board has also completed the actions around the Violence Against Women, Domestic Abuse and Sexual Violence Act. Our preventative actions physical activity, vaccinations and immunisations are ongoing with good progress having been made on childhood vaccinations and smoking cessation. The flu vaccination campaign amongst staff was the most successful ever this year with a 58% vaccination rate. The Physical Activity Strategy implementation work has been proceeding and an action plan is being developed following a Workshop held with partners in Quarter 4.

Corporate Objective 2 - Delivering Excellent Patient Outcomes, Experience and Access



Very good progress was made against the 2017/18 Quality and Safety priorities in the Annual Plan both in terms of the completion of the actions and achieving the measures that were set in the Plan. The Health Board has continued to reduce the number of pressure ulcers and falls reported and we achieved our improvement targets. We have also improved patient experience reporting and performance and we met our target for PREMs/PROMs and compliance standards for serious incidents. We improved our complaints performance but have remaining work to do to meet our target. The rollout of e-prescribing has been delayed due to NWIS issues but the use of e-TOC has improved. All of these are significant achievements that will improve the quality of the services that we offer.

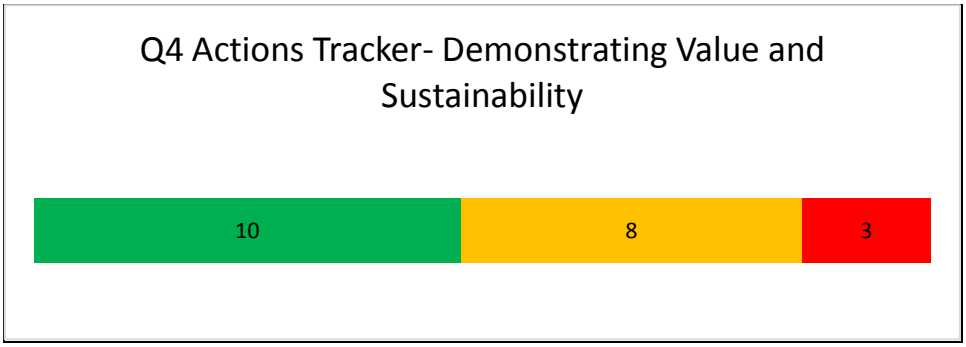
The majority of the actions regarding infection prevention and control are complete or in progress with the exception of the staffing structures and the roll out of ICNet. We are also on-track with the actions to implement enhanced models of primary care through our Cluster Networks developing Telephone First and triage hubs, and have improved our primary care audiology and Musculo-skeletal services. In unscheduled care the 111 service is completely implemented and this means that the Health Board has the lowest number of Healthcare Professional Calls to WAST in Wales. We have developed our frailty models and are continuing our work around SAFER flow bundles. Our Winter Plan was agreed and we have completed the implementation of the Everybody Counts action plan at Morriston.

In planned care, we have the Vanguard Unit in place at Morriston and our revised waiting list policies are in place. There is good progress on improving our outpatients measures, but, despite a lot of work being undertaken, theatre utilisation rates have not improved as planned. A number of actions relating to Bridgend have been suspended following the announcement of the consultation on the future of the locality including the future planning for the potential reconfiguration of breast and urology services. We are continuing our work on regional planning both in the South West and South East Regions.

For cancer patients we are piloting the rapid access diagnostic hub at Neath Port Talbot Hospital services and patient feedback is excellent, however the planned increase in BMT funded by WHSSC has not proceeded due to recruitment issues and the business case for the use of the Tenovus mobile unit was not supported. The remaining actions in this section are proceeding and relate to the targeted intervention priorities of unscheduled care, stroke, planned care, cancer and healthcare acquired infections. However, our performance against these areas is covered in detail in the Integrated Performance Report and is not repeated here.

With regard to the Delivery Plans, we are off-track with the Heart Disease Delivery Plan and this is addressed in the Annual Plan 2018/19. The feedback on stroke is that our current Stroke Delivery Plan is nearly fully implemented and the Oral Health and Organ Donation Plans are being delivered. The other Delivery Plans which were RAG-rated are in progress.

Corporate Objective 3 - Demonstrating Value and Sustainability



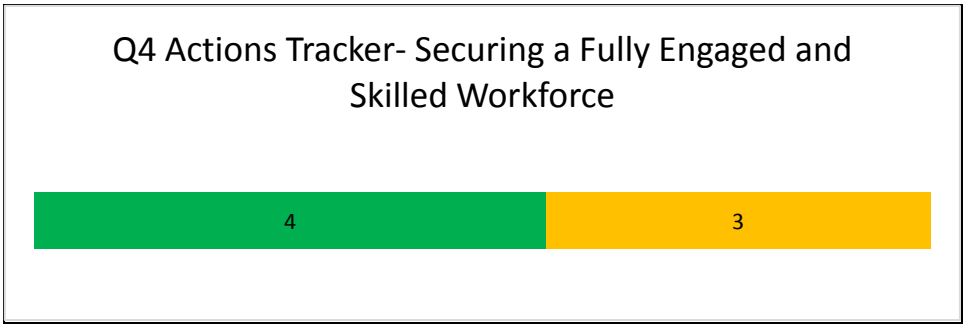
Good progress was made in 2017/18 against many of the Recovery and Sustainability Programme Workstreams with particular progress being made in

clinical variation, procurement, digital enablement (e-TOC), theatre productivity and improving IVF services. However, the outpatient improvement and length of stay measures have not improved as planned.

At the Board meeting in January, the Board was briefed on changes to the approach and organisation of the Recovery and Sustainability delivery programme. In particular, the Board noted that the Programme delivery work streams have been aligned with the financial plan and Executive Directors (as Senior Responsible Owners) had been tasked with identifying robust and detailed plans in preparation for the start of the financial year. The report in March noted that it was not possible at that point to provide full assurance that the programme will deliver the totality of savings required and that further work was being taken forward to improve delivery confidence across the Programme.

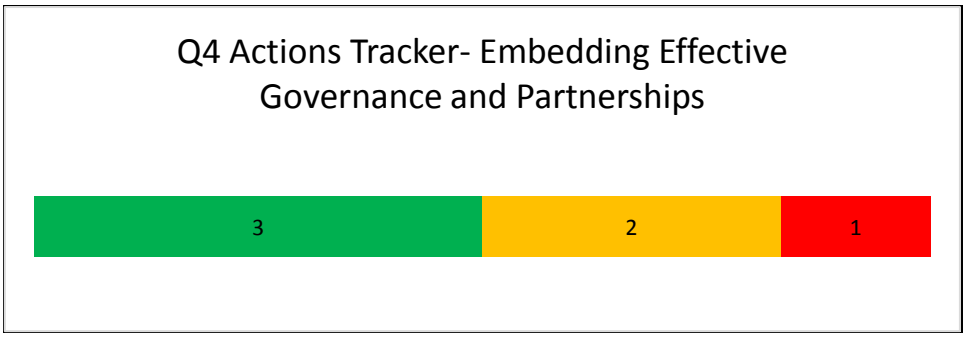
In the sustainability area, in year the Health Board approved the Primary and Community Services Strategy and the Clinical Strategy for Princess of Wales hospital was developed (although this is on hold pending the consultation about the Bridgend locality). The plan for Morriston hospital, and the Strategic Frameworks for Mental Health and Learning Disabilities are in development and the emerging themes were used to develop the Annual Plan 2018/19.

Corporate Objective 4 - Securing a Fully Engaged and Skilled Workforce



We have rolled out leadership and management training in year, with over 300 staff accessing the 'Footprints' programme. We have also undertaken work to review our 'unqualified' staff roles. Our PADR and mandatory training compliance is continuing to improve but there is still work to do to achieve the targets for each area. There has been a very small increase in sickness rates during the year and we will continue to focus on this area, along with improving staff engagement and recruitment and retention.

Corporate Objective 5 - Embedding Effective Governance and Partnerships



The Health Board's financial position improved significantly in year and our end of year overspend was less than our financial control total target. We have also agreed our Western Bay Area Plan and the three Wellbeing Plans for our area. The rest of the actions in this section remain in progress with the exception of the development of the Organisational Strategy, which is about to be restarted This will be supported by the updated of the Clinical Services Plan

3.3 Actions Not Completed

The areas where the end of year position has been assessed as red are set out below along with an explanation of the position. Three of the actions are on hold pending the completion of the Bridgend boundary consultation, which was unforeseen when the Annual Plan 2017/18 was published. The rest of the red actions have either been closed due to alternative arrangements/decisions being made or have been rolled into 2018/19.

Action	Comment
Redesign our structured approach to Infection Prevention and Control, making the best use of existing resources.	This has been assessed as red due to senior vacancies in the team. Temporary solutions are being worked through to improve the situation. This action will roll into operational actions in 2018/19.
Roll out ICNet across the Health Board.	Whilst we are using ICNet reports, it is not fully rolled out as a live system as the interface with PAS is not available. This is due to NWIS issues and has been escalated to them. This action will roll into the 2018/19 plan.
Review opportunities, and if appropriate, finalise business cases to open two additional wards; one at Morriston and one at Princess of Wales Hospital	Considerations are being made alongside Recovery and Sustainability work stream on Service Remodelling redesign to ensure that any vacated space opportunities are factored into the overall bed requirements. This action is closed.
Develop regional dermatology service	Both health boards have agreed to focus on local service delivery at

Action	Comment
	present as initial scoping has not identified any immediate benefits from a regional model. The action is closed.
Review business case and, if supported, implement plan to centralise all breast services at NPTH, within resources	Outpatient services moved but further plan will be considered in light of Bridgend boundary outcome given interdependencies with Bridgend service. This action is on hold.
Implement WHSSC-funded increase in BMT	Recruitment issues have restricted ability to scale up service. We have done 32 transplants in year compared to the target of 50. Discussions are ongoing with Cardiff and Vale around options (Cardiff and Vale host the contract with WHSSC and sub-contract to us). This action will roll into 2018/19.
Develop a plan to use the Tenovus Mobile Unit to increase capacity for chemotherapy (if revenue neutral)	Option suspended to firstly consider alternative capacity options such as home delivery. This action is closed.
Heart Disease Delivery Plan	The Health Board does not have a Heart Disease Delivery Plan. A review of the mechanisms to deliver a Plan will be undertaken in 2018/19 and this was included in the 2018/19 Annual Plan.
Supporting actions in planned care section to transform outpatients through reducing DNAs and follow-ups and validation	Detailed work is underway but not all returns have been received. This action is rolled into the 2018/19 plan through the Recovery and Sustainability programme.
Develop a clinical strategy for Princess of Wales Hospital	The strategy was developed but not considered for approval, and work is on hold pending consultation outcome on boundary change. This action is on hold.
Centralise urology at Morriston	Whilst an internal plan has been agreed the work is on hold due to the pending consultation outcome on boundary change. This action is on hold.
Implement a review process to quantify benefits for existing and new developments	ICF being reviewed through Western Bay. Internal processes now modified to channel investment decisions and benefits realisation through Investments and Benefits Group. This action is included in the 2018/19 plan.
Develop an Organisational Strategy to align all of our existing strategies providing a coherent and consistent organisational direction	This action has rolled forward into the 2018/19 plan.

3.4 Performance at Year End

Whilst this report is not intended to give a full assessment of performance at the year-end (this is the function of the Health Board Performance report within the Board papers), information on the movement of the performance position for the Health Board across 2017/18 is important in the overall context of the plan.

The table below sets out the comparison in the key targeted intervention performance areas comparing March 2017 with March 2018.

		Mar-17	Mar-18
ED	4 hour (%)	75.74%	71.43%
	12 hour (#)	677	1,051
	1 hour handover (#)	525	1,006
	Red Calls (8 minutes) (%)	77.10%	66.60%
Stroke	4 Hour Bundle	32.10%	34.10%
	12 Hour Bundle	92.30%	96.70%
	24 Hour Bundle	78.20%	72.50%
	72 Hour Bundle	88.50%	91.20%
Planned Care	26 week OP only	704	292
	32 weeks	3,485	3,363
	52 weeks	1,275	1,729
	8 week diagnostics	320	29
	14 week therapies	254	-
Cancer	31 says (NUSC)	93%	93%
	62 days (USC)	86%	88%
Infection Control	C. difficile (#)	23	27
	C. difficile (rate)	51.54	51.17
	S. aureus bacteraemia (#)	15	15
	S. aureus bacteraemia (rate)	33.61	31.14
	E. coli bacteraemia (#)	48	40
	E. coli bacteraemia (rate)	107.55	88.98

3.4.1 Unscheduled Care

Good progress was made in the first six months of 2017/18 with improvement in performance as a result of changes in length of stay through new models of care, and implementation of the unscheduled care improvement programme. However, performance in the 2nd half of 2017/18 deteriorated with significant challenges in relation to patient flow and capacity across both health and social care. This was compounded by a difficult winter with a sharp increase in flu prevalence and more latterly, the impact of a cold winter snap, which impacted further on performance in Q4. Despite the deterioration in performance during the winter, the unscheduled care system did demonstrate signs of increased resilience, with an ability to recover performance more quickly than in previous years.

The demand profile has shifted towards increased attendances through the main Emergency Department (ED) sites and a reduction in Minor Injury Unit (MIU) attendances.

Overall ambulance conveyance to hospital was stable compared with 2016/17; however this masks a shift in the prioritisation of patients conveyed with a 17% reduction in green conveyances compared with 2016/17, a 1.3% increase in amber conveyances and a **25%** increase in red conveyances.

Emergency admissions reduced by 2%, but with a **3%** increase in admissions in the >75 population. Emergency medical admissions in the >80 age group increased by 10.8% in February and by 8.6% in March 18 compared with the same months in 2017. Emergency length of stay reduced in the first half of 2017, with an increase in December and January but has now reduced to 6.88 days at the end of March 18. Cancellations for bed reasons reduced by **19%** between Oct and March compared with the same period in 2016/17 and there was a reduction of **9.5%** in the number of medical outliers in 2017/18 compared with 2016/17

3.4.2 Stroke

Performance in 3 of the 4 measures has improved in 2017/18 compared with 2016/17 and we have delivered against the IMTP profile in a significant number of months through the year. Progress was sustained in these areas for the majority of the year but the dip in March on all measures other than the 4 hour bundle is reflective of the wider system pressures.

Delivery against the 4 hour bundle is not in line with the agreed IMTP profile despite an encouraging improvement in performance in Q1 that was not sustained through the rest of the year. The number of confirmed stroke admissions in 2017/18 increased by 14% when compared with 2016/17. Further support is needed to review the stroke pathway with the support of the Delivery Unit to identify opportunities for targeted improvement. Further focussed attention is needed on the out of hours period to improve the identification and assessment of stroke patients who arrive overnight.

3.4.3 Planned Care

Outpatients (over 26 weeks)

- Target achieved. 279 of the 292 are in Oral Maxillo Facial Surgery.
- Plan modest improvement in April and clearance of > 26 week by Oct 2018

36 week waits

- Final Position was 3,363 > 36 weeks. This was considerably outside our planned delivery point of 2,640 and resulted in a clawback of RTT funds by Welsh Government. The winter pressures experienced in March 2018 caused approximately 300 patient and hospital cancellations which had a material impact on the year-end delivery point.
- Plan for Quarter one is to sustain the position as much as possible (no bounce back) and the Health Board is committing resource through Q1 to ensure ongoing reduction in long waiting volumes through May and June

to achieve Q1 trajectory. The forecast April position is around 80 higher than March 2018. The movement between March and April 2017 was 519 adverse indicating far tighter grip in the early part of Quarter 1 this year.

Diagnostics (over 8 weeks)

- 29 patients over 8 weeks March '18. Specialist cystoscopies carried out by single handed consultant and sickness prevented list proceeding. Patients booked in April. 27 Echo patients breached due to sickness late in the month.
- Plan to hold nil for the year for currently reported diagnostics and develop a specific improvement trajectory for reportable cardiology diagnostics in 2018/19

Therapies (over 14 weeks)

- Year-end Nil and plan to sustain through 2018/19/

3.4.4 Cancer

The Health Board has improved and sustained improvements in cancer access targets across 2017/18 but the impact of a difficult winter period resulted in a dip in performance in the final quarter of the year in both the Urgent Suspicion of Cancer (USC) and Non Urgent Suspicion of Cancer (NUSC) measures.

USC performance had shown a steady improvement from a low of 73% at the end of Q1 to a high of 89% during Q3 but this was not sustained in the final quarter (March did however end on 88%). There were 17 USC breaches at the end of March which has reduced from a high point of 36 in May 2017. There are challenges in delivering sustainable solutions in a number of specialties including breast, gynaecology, urology, lung and upper GI

3.4.5 Infection Control

C. difficile

- 24% increase compared with 2016/17
- 78% hospital acquired; 22% community acquired. Little change in these ratios in last 3 years
- 74% of all hospital acquired cases occurred in Morriston and Princess of Wales Hospitals

***Staph. aureus* bacteraemia**

- 11% increase compared with 2016/17
- 51% community acquired; 49% hospital acquired
- 91% of all hospital acquired cases occurred in Morriston, Princess of Wales, and Singleton Hospitals.

***E. coli* bacteraemia**

- 12% increase compared with 2016/17
- 70% community acquired; 30% hospital acquired
- 86% of all hospital acquired cases occurred in Morriston, Singleton, and Princess of Wales Hospitals

4.0 Assurance and Governance

The report will be considered by the Performance and Finance Committee, as agreed during the development of the Annual Plan for 2018/19 before consideration by the Board.

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

5.0 Recommendations

The Board is asked to: -

- **Endorse** the final year report on the implementation of the Annual Plan 2017/18; and,
- **Approve** the assessment for sharing with Welsh Government.

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

Quality, Safety and Patient Experience

The report outlines the good progress that was made in 2017/18 with delivering improvement against the Quality and Safety priorities agreed in the Annual Plan 2017/18. This good track record contributed to the development of the Quality and Safety priorities for the Annual Plan 2018/19.

Financial Implications

The Health Board achieved an end of year overspend that was lower than the financial control total agreed during the development of the Annual Plan 2017/18. The Annual Plan 2018/19 was developed on the basis of the track record of good performance and this contributed to the Board's approval of the 2018/19 plan.

Legal Implications (including equality and diversity assessment)

None

Staffing Implications

None

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

The monitoring report shows that we developed our Area Plan and Well Being Plans with partners in 2017/18.

Report History	The report is the final Quarterly Annual Plan Implementation Report for 2017/18. It will be considered by the Performance and Finance Committee on 23rd May 2018.
Appendices	Appendix A – Annual Plan 2017/18 Monitoring Report

Appendix A. Annual Plan Progress Report 2017/18 - QUARTER 4

Actions and timescale									Impact Measurement	
Corporate Priority		Action	Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures available *(Qtr 4)*
Corporate Objective 1 - Promoting and Enabling Healthier Communities										
Implement the priorities of our Early Years Strategy to give children in our area the best start in life and prevent adverse childhood experiences	1	Publish our Children and Young People's Strategy	Q4					• The Head of Nursing of Neonatal and Children's Services has undertaken the development of the CYP Strategy. The work commenced in May 2016 and subsequently resulted in the presentation of the completed strategy to the Health Board meeting on September 28th 2017. The strategy was signed off by the Board in September 2017. Children's services to lead on the development of an implementation plan	Children and Young People's Strategy published by end 2017/18	
	2	Improve our childhood vaccination rates within available resources through actions such as: appointing high-level immunisation champions and vaccination champions to cover every ward, unit or practice; taking every opportunity to check a child's immunisation status; and actively promoting childhood and flu vaccinations.	Q1-Q4					• Dedicated Ward Nursing staff in situ should a child need a vaccine but no proactive vaccination. • Childrens Immunisation Group re-established Sept 17 with P/care and GP lead membership. ChIG Action Plan refreshed with All Wales National Improvement Programme for childhood immunisations. New pathway drafted re defaulted child immunisations appointments. Draft business plan for HV immunisations team under review for discussion with GP clusters. • MMR task & finish group established September 2017 with GP Chair. Primary Care Team developed and issued guidance to GP Practices re cancelled immunisations clinics.	Childhood vaccination rates at age 4 reach 90% across all our communities and continue to improve towards achieving the 95% target	88.1% *(Dec17)*
	3	Reduce Violence against Women, Domestic Abuse and Sexual Violence by implementing 'Ask and Act' in our pilot sites	Q1					• 11268 (80%) staff presently completed on-line "Ask and Act" Group 1 training. 100% of staff were expected to have completed by 31st March 2018 (statutory requirement) however this was not achieved. This is comparable to other Health Boards in Wales, none of which has achieved the required target. Feedback will be given to Welsh Government in the annual report. Continues to be monitored through the Safeguarding Committee and escalated as necessary to the Service Delivery Units • Wider implementation of Group 2 "Ask and Act" training across the Health Board commenced in February 2018. Individual Service Delivery Units to deliver their own implementation plans. • From April 2018, the HB has commenced delivery of the forecasted training as identified in the local training plan - 5 out of the 6 Service DUs are compliant in their planning and delivery of sessions and work is in progress to address and support the remaining DU to gain their compliance. Challenges exist around staff being released to attend.	Compliance with our statutory duty to roll out 'Ask and Act'.	80% completion of Group 1 training by staff

Actions and timescale									Impact Measurement	
Corporate Priority		Action	Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures available *(Qtr 4)*
Reduce smoking	4	Implement actions within Delivery Units within resources to reduce smoking such as: senior level tobacco control champions and a champions to cover every ward, unit or practice; Health Board ownership and delivery; use of Making Every Contact Count (MECC) training including uptake of e-learning; implementing smoke-free environments on all our sites; and actively referring staff and patients to smoking cessation services.	Q1-Q4					•Integration of ABM Cessation services with Help me quit continues. ABM Cessation Services Steering group meets quarterly. Reporting to Q and S Forum and Committee •All 84 level 3 community pharmacies that were commissioned are now accredited. This will rise to 100 by April 2018. Service Improvement plan in place • Hospital cessation service undertaking a continued programme of staff training to improve management of inpatient smokers •Maternal smoking being progressed at part of NHS Wales National Improvement programme. Monthly meetings held to monitor progress. ABM Maternity Smoking in pregnancy working group established. Improvement plan in place • Work continues with Primary Care DU to embed tobacco/cessation priorities in cluster plans and increase referrals into Help Me Quit services • Pilot project commenced in March with 2 Swansea clusters (28 GP practices) to increase referral to Help Me quit services. CO monitors provided to all practices. Smoking Behaviour change training undertaken with 40 practice staff Making Every Contact Count (MECC): • Board and Exec team paper on developing a sustainable programme for MECC , (incorporating health literacy) in the HB during 2018/19 being taken by DPH to Exec team during April 2018. Work progressing with Health Board's co-production implementation group to integrate MECC and coproduction approaches through four levels – induction, e-learning, workshops and train the trainer. • MECC level 1 e-learning developed and now available on ESR for NHS Staff and on the MECC website for non-NHS staff	Smoking prevalence falling in line with trajectory to meet 16% prevalence by 2020	21% *(2016/17)*
									Continue to improve trajectory towards 5% of smokers to make a quit attempt via smoking cessation services; with at least a 40% CO validated quit rate at 4 weeks.	Smokers making quit attempt= 2.5% CO validated= 52.1% (Jan-18)
									Health board set target for uptake of MECC	not yet decided
Reduce obesity and increase physical activity	5	Implement our Physical Activity Strategy	Q1-Q4					• ABM Physical Activity Strategy finalised by Physical activity alliance • Letter from ABMU Chair (and chair of Alliance) has been sent to strategic partnerships and PSB partner organisations, asking for endorsement and commitment to delivery of the Physical Activity Strategy •Workshop held in Q4 to develop the ABM Physical Activity Action plan with partner organisations. Action plan in development	Increase in physical activity rates as measured by national surveys of adults and school aged children	
	6	Implement actions within Delivery Units within resources to reduce obesity such as: use of MECC; providing and promoting healthy eating options for staff and patients; and ensuring that hospital IT systems record BMI and physical activity levels.	Q1-Q4					• MECC coordinated with co- production agenda, steering group established and programme of training activities (4 levels) are in development. • Review of in-house & commercial, non-patient food provision to promote healthy eating established within Health Board Nutrition and Catering action plan. Partial compliance with Welsh Government Vending Policy. • Limited progress in embedding recording of BMI and physical activity levels within hospital IT systems. Measurement and recording of BMI established within maternity services.	Reduction in % of population who are obese	2.1% with a BMI of 40 and over *(2007-2012)*
									Obesity as measured in reception aged children.	
									% of children aged 4-5 years who are obese	11.8% *(2014/15)*
									Working towards capturing maternal weights at booking	recorded

Actions and timescale									Impact Measurement	
Corporate Priority		Action	Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures available *(Qtr 4)*
Meet or exceed Welsh Government targets on immunisation and vaccination within available resources	7	Implement actions within resources to improve our flu vaccination rates for 1, staff; 2. pregnant women, over 65s and the 'at risk' groups	Q3-Q4					• ABM UHB's flu vaccination campaign began in September 2017. At present no IVOR reports have been generated to comment on current performance. • The ABMU Staff Flu Vaccination Campaign has been supported with additional resources and at the end week two, 5006 staff had been vaccinated. At 21st Feb 2018, 9453 staff had received the vaccination and 58% of front line staff had been vaccinated. • As the Flu season draws to a close during Q4, 9553 staff have received the flu vaccine (58.5% of frontline staff), making this the Health Board's most successful staff campaign to date. A multi-disciplinary review of the campaign has been undertaken and Public Health Wales has been informed of data collection issues that may have prevented ABMU reaching the Tier 1 Welsh Government target of achieving 60% of frontline staff receiving the vaccination.	Influenza immunisation rates to reach 75% in clinical at-risk groups, pregnant women and those over 65 years of age.	Clinical risk= 43.7% Over 65 yrs= 65% Pregnant women= 81.5% (2016/17)
									Influenza immunisation uptake rates to reach 60% in our staff.	58.30%
Corporate Objective 2- Delivering Excellent Patient Outcomes, Experience and Access										
	8	Reduce the number of grade 3+ pressure ulcers	Q1-Q4					• Q4 saw an increase in inpatient grade 3+ pressure ulcers incidents (Grade 3, 4, unstageable and suspected deep tissue injury (SDTI)). The rate of incidents for Q4 was 61, compared to 55 in Q3. Winter pressures on the ambulance service and occupancy of in-patient areas increase the challenge for staff in preventing pressure ulcers. Morriston Hospital has seen a direct correlation with increased USC pressures and pressure ulcer development. • The Health Board has not achieved its target to reduce inpatient grade 3+ pressure ulcers by 10%. Target figure - 188, actual figure - 219. • The HB has exceeded its target of 10% reduction in the number of severe pressure ulcers. In the year 2016/2017 196 pressure ulcers were reported to WG as Serious Incidents, by 2017/2018 this figure has reduced to 168. • A review of Serious Incident pressure ulcers occurring between April 2017 and March 2018 has been carried out to identify themes for causal and contributory factors for pressure ulcer development. The findings and implications will be reported by the end of May 2018 and will contribute to the development of the Strategic Quality Improvement Plan (SQuIP) for reducing the number of avoidable pressure ulcers. • A pilot workshop for developing the skills of pressure ulcer peer review scrutiny panel members was held in February. Feedback from the workshop was analysed and a plan for scrutiny panel education developed. • Roll out of Pressure ulcer scrutiny panel development workshops is underway for HB staff involved in investigating and scrutinising pressure ulcer incidents. The workshops will be concluded by the 18th May. Following the conclusion of the panel development workshops, the new all	10% reduction from 196 in 2016/17 (188) in 2017/18)	Q4 Figure - End of Year Figure - 168

Actions and timescale								Impact Measurement	
Corporate Priority	Action		Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures available *(Qtr 4)*
Implement the priorities of our Quality Plan for 2017/18 (see also stroke and HCAI sections)	9	Reduce falls causing harm	Q1-Q4					• The number of Falls reported via Datix for Q4 is 1,007, of these 102 were reported as causing harm. These figures are an increase in incidents compared to Q3 (994 inpatient falls, 302 causing harm). • The Health Board has achieved its target of reducing inpatient falls causing harm by 10% during 2017/18. Target figure – 1644, actual figure - 1402 • The FPMG continues to meet monthly actions from the meetings have included: • The Falls policy has now been reviewed, the policy will go to members for approval outside the meeting for ratification. • All SDU's have Falls Scrutiny panels, Primary and Community panels all agreed outcomes from the scrutiny panel will be presented to the FPMG to enable shared learning. • The FPMG has completed a training needs analysis. A training package was sent to members of FPMG for implementation from March 2018. • Base line audit and review of all equipment relating to falls management was discussed at the February 2018 FPMG. The Health Board have purchased via Charitable Funds 60 high low beds with roll out planned in March 2018. Further work was scheduled for April 2018 to review other equipment needs. • Chair of FPMG has requested from HB manual handling lead an outline of the asset register to ensure accurate HB picture by March 2018. Further work was scheduled in April 2018 to review overall equipment needs. • FPMG membership was reviewed in February 2018 (and monthly) going forward to establish if the group would benefit from more senior clinical representation. • Work continues with the Datix user group to configure the system to	10% reduction from 2016/17 (1648 in 2017/18)	Q4 figure - End of Year Figure - 1402
	10	Meet WG compliance standards for serious incidents	Q4					• Performance against the WG target to gain assurance on the reports within 60 working days (80%), remains consistently above the 80% target since April 2017. Performance over Q4 has increased from 85% in January to 92% for both February and March 2018. All submitted closure forms received assurance by WG in January 2018 evidencing continued improvement in the quality of forms submitted.	Meet 80% target	92% - March 2018
	11	Improve complaints performance	Q4					30 day response rate • The overall Health Board response rate for 30 day responses, on aggregate, for the period April 2017 to February 2018 is 76%. • During the Q4 period the Health Boards 30 day response rate was 81% for January 2018 and 64% for February 2018. March 2018 data can not be included in the Q4 update due to waiting for 30day response outcome, followed by time to scrutinise data. • The Deputy Director of Nursing & Patient Experience is continuing to hold performance meetings with the SDU Directors to monitor trends and challenge the 30 day response rate for SDU's as well as the quality of responses 2 day response rate • 2 day acknowledgements are consistently being maintained at 100% during the Q4 period and throughout 2017/18. • The staff within the Units are continually improving their complaints processes with the aim of consistently achieving the 80% target of sending a response to complainants within 30 working days while ensuring the quality of the investigations and responses sent is appropriate.	Meet 80% target for response within 30 working days	64% *(Feb-18)*
									Meet 100% target for acknowledgement within 2 working days	100%

Actions and timescale								Impact Measurement	
Corporate Priority	Action		Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures available *(Qtr 4)*
	12	Improve patient experience feedback (PREMs) and PROMs	Q4					% Family and Friends who would recommend the HB - For Q4 the overall score 95%. The year on year figures 2016-2017 was 94% and 2017-2018 was 95% increase overall of 1% • Level of feedback per discharge: The level of feedback has continued to remain above the target figure of 15% in Q4. The level of feedback improved from 22.1% in January to 25% in February 2018. March 2018 saw a reduced level of 23%, but still above target. With the exception of April 2017, the Health Board has consistently achieved above the 15% target. • Friends and Family quarter 4: The satisfaction score for quarter 4 was 95% and the number of returns 15,937. • End of the year Friends and Family: The number of Friends and Family returns for 2016-2017 was 49,792. The number of Friends and Family returns for 2017-2018 was 64,405. Increase of 14,613 surveys year on year. • All Wales Survey quarter 4: The satisfaction score for quarter 4 was 85% and the number of returns 752. • End of Year All Wales Surveys: The number of All Wales surveys completed for 2016-2017 was 5,154. The number of All Wales surveys completed for 2017-2018 was 4,070. A decrease of 1,084. • Quality Priority – Stroke: Patient Experience Team are working with the stroke occupational therapist service in POWH. Early discussions have taken place and the questions for the survey are being developed. The aim is for the information collected to be used to guide service needs and to develop and improve the input occupational therapy provides to stroke patients. • Cancer: After a successful meeting with the National Cancer Network, the Health Board was approached by Macmillan to work together on developing a bespoke survey. The aim is to capture cancer patient feedback from the GP pathway. There was a meeting in January with Upper Valley cluster lead, ABM Patient Feedback Team and GP and Macmillan regional nurse. A set of questions have been discussed and bespoke surveys are being developed for comment. • Patient stories: Ongoing work developing the ABM Patient Stories	Improve % Family and Friends who would recommend the Health Board by 1%	95%
									Improve the level of feedback per discharge to 15%	23% (March 2018)
	13	Roll out e-TOC	Q4					• Every Unit has targeted improvement adopting a “no summary – no discharge approach” • There has been a sustained improvement in performance and it is now possible to target individual clinical teams. • During Q4, 72% of ETOC forms were approved and sent, however only 63% were approved and sent within 5 working days (an increase of 2% since Q3).	Improve e-TOC compliance from 50% to 70%	72% of ETOC forms approved and sent, 63% of which within 5 working days.
	14	Maintain percentage of patients with NEWS scores	Q4					• The target is that 100% of adult inpatients have their NEWS score recorded. The HB aim is to maintain at 98% or above. In 2017-18 this was met or exceeded in Qs 2 & 3 but dropped slightly in Qu 4. • Paediatrics are taking part in a research project to determine the best approach	Maintain at 98%	96.30%
	15	Suicide prevention	Q1-Q4					• Regional forum relaunched covering the geographical area served by Hywel Dda and ABMU Health Boards. Regional Forum met on 2nd October 2017 and using the national guidance issued in will produce a multiagency action plan. • Specific group set up by South Wales Police to write a Suicide Prevention Strategy for Bridgend, as per Welsh Government’s requirements in Talk to me 2. Health Board participating in National Clinical Audit & Outcome Review Programme on Suicide in Children and Young People.	Measures in development	

Actions and timescale									Impact Measurement	
Corporate Priority	Action		Timescale	Progress				Quarterly commentary on progress	Measure	Current position where numerical measures available *(Qtr 4)*
				Q1	Q2	Q3	Q4			
	16	Roll out e-prescribing	Q2-Q4					• Recruitment of ABMU e-prescribing project team complete with the exception of the data analyst. • JAC contract signed and upgrade to live instance of JAC complete. • Delays in the design of JAC integration with WCP and delivery of WCP upgrades is impacting on "go live" planning. Revised dates to be worked through with NWIS	e-Prescribing rolled out in line with Digital Programme	
Reduce our rates of healthcare acquired infections to meet or exceed Welsh Government targets	17	Redesign our structured approach to Infection Prevention and Control, making the best use of existing resources.	Q2					• Clinical Lead for Microbiology Services appointed for Swansea PHW Lab is a positive first step in reviewing the Microbiology services resource deficit. • Reduction in senior IPC expertise when Assistant Director of Nursing IPC left the organisation on 29th September 2017. This post has remained vacant whilst reviewing service design. • Band 8a retired at end of March 2018, significantly reducing strategic leadership resource. Mitigation - Band 8a will return at 0.5 WTE from mid-April 2018. • Additional temporary solutions currently being worked through to improve the situation.	Reduce rates of clostridium difficile infections to 30/100,000 by end of March 2018	52.91
	18	Adopt ANTT across the Health Board using existing resources	Q1					• More than 3500 ABMU staff completed ANTT e-learning programme. • Direct Observation of Practice assessors in each Service Delivery Unit undertaking competency assessments. • All Wales ANTT policy adopted by ABMU in November 2017. • ANTT has been adopted across the Health Board; staff who have completed e-learning programme is captured via ESR. Delivery Units to keep records of staff who have passed competence assessments.		
	19	Review all existing policies and SOPs to ensure they are current and evidence-based.	Q3					• 75% IPC policies are current • Public Health Wales has approved All Wales National Infection Prevention and Control Manual, which is to be launched by Chief Nurse for use in NHS Wales. This will supersede all previous IPC policies.		
	20	Roll out ICNet across the Health Board.	Q1					•Timely reports received from ICNet; • Weekly generated reports on bacteraemias circulated to Delivery Units; • ICNet has been invaluable during end of December/beginning of January for monitoring trends of Influenza in a timely way. • Interface with PAS still not available; this is linked to an NWIS change of integration platform. Information Department has escalated this to NWIS. Information Department keeping IPC Team updated. Once interface established, there will be local validation to ensure data transfer is correct before the PAS link goes live.		
	21	Implement the year 1 recommendations of the decontamination review.	Q4					• Centralisation of endoscopy decontamination in HSDU has gone live in Singleton • New washer disinfectors in Morriston facilitated removal of local decontamination equipment in theatres • Introduced automated process for decontamination of nasendoscopes in Morriston. •NWSSP Authorised Engineer for Decontamination has awarded Amber/Green rating for POW Endoscopy unit . JAG Accreditation Review on 20/04/18; report anticipated in May 2018.	Reduce rates of MSSA infections to 20/100,000 by March 2018	37.36

Actions and timescale									Impact Measurement	
Corporate Priority	Action		Timescale	Progress				Quarterly commentary on progress	Measure	Current position where numerical measures available *(Qtr 4)*
				Q1	Q2	Q3	Q4			
	22	Complete the isolation pathway in Morriston by developing three isolation rooms	Q4					• Building work completed on the negative pressure isolation facility in Morriston. Statutory commissioning checks to be completed. NWSSP due to undertake commissioning and validation checks of the air handling unit week commencing 16/04/18.	to 30/100,000 by March 2018	
	23	Review opportunities, and if appropriate, finalise business cases to open two additional wards; one at Morriston and one at POWH	Q1					• No definitive plan in place for additional wards in Morriston and Princess of Wales		
Improve our stroke care and performance to meet or exceed Welsh Government targets	24	Continue to implement unit –based multi-disciplinary action plans to improve compliance with the stroke measures	Q1-Q4					• Q3 improvement maintained in 12, 24 and 72 hour bundles. The 4 hour access bundle has deteriorated and has been affected by workforce capacity and unscheduled care pressures. • Out of hours workforce capacity and cover remains a risk in terms of stroke compliance • Increasing stroke demand. • Remodelling stroke demand with support of Delivery Unit to assist with development of HASU model (ABMU and Hywel Dda). External funding has been secured to support the appointment of a project manager for 1 year to support the development of the HASU service model. • Weekly MDT review of stroke bundles and compliance to support continual improvement approach in the stroke pathway. Key actions include ongoing recruitment, training and awareness of staff on the stroke pathway.	By end March 2018: Achieve 72% compliance with <4 hours bundle Achieve 95% compliance with <12 hours bundle Achieve 72% compliance with <24 hours bundle	 34% 96.70% 82.90%
	25	Reduce risk factors through wider prevention agenda	Q3-Q4					• Implementation of Directed Enhanced Service for INR from October • The Health Board is implementing a suite of improvement actions in 2017/18 to support people to live a healthy lifestyle, including smoking cessation, and weight management programmes.	Maintain 97% compliance with <72 hours bundle	98.00%
Sustaining and improving our performance against the Welsh Government unscheduled care targets supported by targeted intervention at Morriston Hospital	26	Maximising the role of 111 in selecting the right access option.	Q1-Q4					• 111 continues to evidence a positive uptake of the 111 service by paramedics, care homes and redirection to alternative health care professionals. • Paramedic, pharmacy and nurse practitioner input is provided to 111 to enhance the team capacity and provide increased resilience and redirection of patients to alternative services. •Out of hours GP cover is becoming increasingly challenging . Ongoing GP recruitment in the short term, with longer term sustainability options under development.	Overall Welsh Government measures for Unscheduled Care by 4 hours – 90% 12 hours – 300 1 hour – 100 Red calls – 76% Reduction in conveyances to hospital	 71.36% 1051 1006 66.6%
	27	Ensuring existing alternative WAST and Community Resource Team pathways are used appropriately and consistently across the Health Board area.	Q1-Q4					• ABMU has the lowest proportion of HCP conveyances (green calls) in Wales. • New pathways of care, the 111 service have supported the reduction of green calls and redirection of calls. The acute clinical care team is piloting direct access to ambulance control to select appropriate patients they can manage at home, avoiding conveyance to hospital		Evidence of lower HCP (lower acuity calls) being conveyed to hospital compared with December 2016

Actions and timescale								Impact Measurement	
Corporate Priority	Action		Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures available *(Qtr 4)*
	28	Implement site change plans within resources to increase the number of patients following Ambulatory Emergency Care pathways in accordance with BAEC guidance.	Q4					• Evidence of continuous improvement approach to managing increased number of patients through ambulatory care pathways in line with RCP Acute care toolkit 10. Ambulatory surgical assessment unit piloted for 2 weeks at Princess of Wales hospital in February/ March. Positive impact on admission avoidance - further PDSA for one month planned in May. Workforce capacity impacts on ability to sustainable provide ambulatory care models at present.	Target for 2017/18 is AEC on all sites 9am-5pm Monday-Friday	
									Reduce 4 hour and 12 hour waits	March 2018 4, 12 and 1 hour ambulance handover performance deteriorated by 4.31%, 55% and 48% respectively when compared
	29	Improve compliance with the SAFER flow bundle on every ward in every hospital supported by an internal accreditation process.	Q1					• Executive led patient flow workstream in place to support ongoing implementation of SAFER flow focus on: * Red to Green days * Estimated Date of Discharge * Increased number of patients discharge home before lunch * Increasing communication and awareness of the impact of delayed discharge on patient outcomes (deconditioning). SAFER flow awareness sessions held within the delivery units to promote and support systematic implementation of SAFER flow. Health Board wide sessions arranged 8th and 9th February externally facilitated by NHS improvement England. HB is supporting the national#endpjparalysis campaign between April and July.	Number of wards with SAFER patient flow bundle implemented.	
									Reduce 12 hour waits in ED	55% increase in 12 hour waits
									Reduce discharge fit and DToC patients.	DTOCs decreased by 42 (from 71 in Mar 17 to 67 in Mar 18)
	30	Rolling out the Clinical Portal and ensuring it is used effectively.	Q1					• WCP all Wales results viewing, electronic test requesting and access to the GP record is deployed and available for use. Uptake of this functionality has increased during Q4. 57 out of a total of 256 locations across ABMU are now actively requesting pathology tests electronically via WCP. During March 2018, 4,488 pathology tests were requested electronically, 98,269 pathology results were viewed in WCP with the GP record accessed via WCP 5,064 times. • 97% of all electronic referrals are being prioritised electronically via WCP.	Reduce LoS and bed days used.	
	31	Increase the number of patients having a frailty assessment at each acute site underpinned by the Comprehensive Geriatric Assessment	Q2					• Plans to enhance frailty models continued during Quarter 4 through additional non recurrent resources from Welsh Government through : Accelerated Placement Team in NPT Senior community nurse at Singleton SAU and support to continue and develop the frailty service at this hospital Embedding redesigned frailty model in PoW Frailty service in Morriston with increased physiotherapy support.	Reduce avoidable admissions and associated beddays	DTOCs decreased by 42 (from 71 in Mar 17 to 67 in Mar 18)
									Reduce LoS and DToCs	
	32	Increase the health and social care capacity available to support admission prevention and timely discharge through effective use of ICF	Q3					• Recruitment underway to enhance community capacity for frailty services supported through ICF funding (£600k) • Increased risk in relation to domiciliary care capacity – particularly in Swansea where despite targeted recruitment campaigns private provider capacity remains problematic.	Reduce 12 hour waits in ED	55% increase in 12 hour waits
									Reduce discharge fit and DToCs	DTOCs decreased by 42 (from 71 in Mar 17 to 67 in Mar 18)
									Reduce LoS and beddays used	
	33	Continue to implement any additional recommendations of the external review of performance at Morriston Hospital as part of targeted intervention status	Q1-Q4					• Ongoing implementation of the USC improvement plan supported by Everybody Counts approach in Morriston. Additional actions implemented to support patient flow from non recurrent winter pressures funding and learning from Breaking the Cycle.	NHS Wales Outcomes Measures	

Actions and timescale								Impact Measurement	
Corporate Priority	Action		Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures available *(Qtr 4)*
	34	Review all the opportunities to increase bed capacity at Morriston including reprovision of the therapies space	Q1 & Q4					• Therapies solution not achievable in 2017/18. • Vanguard unit installed and operational at Morriston from January 2018 to support increased ambulatory care and emergency flow capacity and protect elective operating capacity. Support being sought to retain Units through until end of Winter 2018/19	Plans agreed in Qu 1 to increase bed capacity at Morriston (therapies re-provision in Qu 4)	
	35	Improve winter resilience through effective multi-agency plan agreed by August 2017 (revenue required)	Q2					• Winter plan submitted to WG on 22nd September. Focus on * Breaking the cycle i January - action plan developed to support sustainable improvement in patient flow. * Enhanced capacity – hospital and community * Targeting increased support and improvement for 5 big conditions/admission avoidance. • Additional targeted investment agreed - £500k • Additional non recurrent investment confirmed by WG in January 2018 - allocated to support increased capacity/ staffing across the USC system. Challenges in securing and optimising increased workforce capacity and models of care due to late confirmation of additional resource by WG.	NHS Wales Outcomes Measures	
	36	Continue to develop primary care focussed pathways for diabetes and respiratory medicine through our Commissioning Boards	Q1 & Q4					• High level pathways and community models have been developed for both Diabetes and COPD; • Outline change cases have been approved by the Investments & Benefits Group (IBG) for both Diabetes & COPD and full business cases were considered by the Group scrutiny panel in December 2017. • The Diabetes full business case was not taken to the IBG meeting and requires further work up. Discussions will be progressed during Q1 of 2018/19 on how to proceed with the outcomes of the PBMA, and the DES. • The COPD full business case was approved in March for funding through an ABM invest to save fund for 24 months. • Strong clinical engagement and input across the pathway for both services.	Number of diabetes patients having new and Follow up outpatient appointments in secondary care	Dec-16 compared with Dec-17: Endocrinology New outpatient appointments= 18% reduction Follow-up attendances= 13% reduction
									Number of clusters with pulmonary rehabilitation and early supported discharge for COPD	Pulmonary Rehab= 11, COPD= 1
		Increase the number of clusters offering:								
		· Telephone first access models	Q3					• Standards developed in consultation with the LMC and CHC and endorsed by the Primary and Community Services Board in October 2017. • Q3-4 Telephone First standards formally launched on 27th February 2018. All triaging GMS practices to be invited to self-assess against the standards and action plan how they will address any shortfalls in their current operating model against the standards. • Telephone First Access introduced into the Health Board managed practice Q4 2018/19. • Data collection on the number of practices using telephone triage to be collected Q1 18/19 via National telephone triage survey.		

Actions and timescale								Impact Measurement	
Corporate Priority	Action		Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures available *(Qtr 4)*
Improving access to enhanced models of primary care	37	· Integrated triage hubs	Q2					• Neath Pacesetter hub consolidation and evaluation progressing, to inform Business case for sustainable service going forward. • Learning from the hub being rolled out to other clusters – similar hub emerging in Cwmtawe, Bay, Bridgend West, Upper Valleys and planned for Afan; adapted to local geography and practice access models • Hub and Spoke Pacesetter developed and submitted to WG for funding for 2018/19 to support the development of hub spokes in the valley communities and pump prime the planning of the hubs in Swansea and NPT.	Number of clusters offering these services	1
		· Advanced audiology	Q3					• Advanced Audiology service expanded from previous 3 pilot cluster sites to include a 4th Cluster in 2017/18. • Evaluation framework and benefits realisation in place to support the development of a business case for further investment / realignment of current resources to roll the audiology hub model out to the other 7 clusters in the HB over the next 3 years (in line with staff training and funding availability).		4
		· MSK services	Q3					• Five clusters have invested in Triage and/or treat Physiotherapists in their cluster/hub services; joint posts have also been recruited to between the cluster and MSK. • A GP led Cluster ultrasound guided joint injection pilot has been initiated in Bridgend North; evaluation awaited, may impact on secondary care pathways.		5
Sustaining or exceeding our performance against Welsh Government planned care targets, maximising the opportunities of the national planned care programme to establish sustainable solutions, subject to available resources.	38	Roll out Transforming Outpatients programme across all specialties and Units	Q1					• ABMU Outpatient Improvement Group continues to feed into National Steering Group. ABMU Reporting mechanism for 2018/19 identified with the Group to report to the Planned Care Supporting Delivery Board. • Continued focus on new and alternative ways of delivering New and Follow Up appointments; DNA and Delayed Follow Up reductions; increased clinical and patient engagement. • Continued scrutiny from ABMU Performance and Finance Committee and WG Quality and Delivery on Delayed Follow Up position. • Outpatient Appointment Text Reminder implementation ongoing.	Reduction in number of new and follow up outpatients	Apr 16-Mar 17 compared with Apr 17- Mar 18: New outpatients attendances reduced by 1.6% Follow-up attendances reduced by 1.7%
									Reduction in DNAs and CNAs	2017-18 compared with 2016-17: DNA for new outpatients reduced by 0.4% DNA for follow-ups reduced by 0.5%
									Improved patient satisfaction	96% family and friends who would recommend the Health Board

Actions and timescale								Impact Measurement	
Corporate Priority	Action		Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures available *(Qtr 4)*
	39	Implement surgical efficiency and effectiveness plans in each Delivery Unit	Q1-Q4					**Morriston Hospital** • Priority focus on unscheduled surgery at Morriston with establishment of second CEPOD and second orthopaedic trauma operating Monday to Friday. 2nd CEPOD established (sept 2017) further work on 2nd orthopaedic trauma required. • Maximise the utilisation of elective operating capacity in Morriston Hospital for cancer, urgent and complex surgery and balance theatre and bed capacity (Theatre improvement project) • Dual site model for bariatric surgery running for 12 months, delivery of significant improvements. **Singleton Hospital** • Increased pre-assessment capacity planned for Ophthalmology (Singleton) • Job planning focus on theatre allocation and utilisation – maximising backfill opportunities (Gynaecology)	Improve theatre utilisation Reduce cancellations Reduce LoS Increase productivity through core capacity Reduce WLIs and outsourcing	Mar 18 compared with Mar-17: Theatre utilisation rates reduced by 3% (73% to 70%)
	40	Refresh and implement updated RTT policies in line with new guidance to support delivery of RTT targets	Q2					• Local Patient Access Policy to support managers and clinicians in the appropriate management of RTT pathways has been developed and implemented across the Health Board. • Awareness sessions delivered across all Service Delivery Units within the Health Board targeting key RTT keys • All internal corporate guidance documents have been revised to align with new waiting times rules.	Guidance issued to units Training delivered Improved DNA rates, reduced cancellations	Guidance issued to Units and targeted training delivered throughout Q1 by RTT manager. DNA rate for new outpatients reduced by 0.4%
	41	Implement the sustainability requirements within the national Planned Care Programme Plans for the 4 Phase I specialties.	Q1-Q4					• National Priority targets for Follow Up - Plans in place to make continuous improvement through to agreed target dates for each specialty. • Clinical variation themes – cataracts / Orthopaedic prosthesis -work completed with agreements for increased Cataract procedures per theatre session in place and a reduction of available orthopaedic prosthetics • Commissioning / implementing investment changes - processors in Path Labs, new theatre stacks etc. to improve efficiencies	Delivery of Transitional plans and milestones within each plan achieved	Good progress being achieved for F/U Plans. Audiology and Ophthalmology utilisation will need monitoring. .
	42	Develop sustainability plans for the next tranches of the national Planned Care Programme, starting with dermatology	Q2-Q3					• Dermatology Planned Care Board set up with Unit Medical Director Chair • Existing practices / Pathways under review against National Action plan for the Specialty • Electronic systems rollout to General Practice - Cameras available for GP's and In Swansea as well as a roll out of Web based systems in place. NPT and Bridgend reviewing option for Web based solution.	Sustainability plans submitted	Discussions ongoing with National Information group around agreeing a National dataset.

Actions and timescale								Impact Measurement	
Corporate Priority	Action		Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures available *(Qtr 4)*
	43	Develop regional pathways and services:							Welsh Government support for submission of business cases setting out quantifiable benefits in terms of service sustainability across the region.	
		· regional vascular surgery service	Q1					• Work on track for vascular with TIA pathway agreed and lower limb at risk pathway agreed.		
		· regional dermatology service	Q2					Not being progressed at present. • Focus for dermatology is local service delivery		
		· regional ophthalmology service (review in 2017/18, implementation in years 2/3 is supported)	Q1					• Ophthalmology workshop held in September. Short, medium and long term actions identified. Full plan in development.		
	44	Submit a business case to Welsh Government for a regional elective orthopaedic centre at Morriston	Q1					• Healthcare Planners appointed to review scope of development and report submitted. • SOC already in preparation, will need scope and costs to be updated • Workshops have been held with HDd to review scope of the project and to consider the demand for a Regional Orthopaedic Centre against Elective Orthopaedic Centres in both Health Boards	Supports unscheduled care performance across HB system. Deliver 26 and 36 week waiting times target for orthopaedic services. Sustainable in house provision of orthopaedics for Swansea and agreed elements of Hywel Dda population.	
	45	Pilot the rapid access diagnostic hub (Danish model) at NPTH (Revenue funded by the Cancer Innovation Fund).	Q1					Two year pilot at Neath Port Talbot Hospital funded by the Cancer Network live as at the 6th June 2017; • Evaluation framework agreed, and reporting structure in place; • Level of referrals are increasing, and the Clinic has now extended to two sessions a week and has further expanded geographically to 7 out of 11 GP clusters. Health Economic Evaluation is currently underway with Swansea Uni with regards to continuing viability and improvements. Diagnosis rate 9% (Danish model – 8-10%), but other significant serious conditions have been identified. Patient feedback has been excellent.	Cancer Commissioning Board to report on pilot – comparison of stage of cancers at diagnosis	
								•At the end of the 2016/2017 financial year, the Health Board had treated 3322 patients against the USC and NUSC pathways, an increase on the previous year. To the end of February 2018 of this financial year the Health Board has treated 2970 patients. This is below average, and attributed to the low volume of patients treated in the months of April and December 2017. Backlog has been steadily increasing since the end of February despite the weekly scrutiny meeting. This suggests a potential lack of capacity to track and focus at a time where leave and emergency pressures have	Maintain 98% compliance with non-USC cancer target	93%

Actions and timescale								Impact Measurement	
Corporate Priority	Action		Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures available *(Qtr 4)*
Sustaining and improving performance against Welsh Government cancer targets using the outcome of the Capita demand and capacity review	46	Implement actions not requiring revenue investment in our Cancer Delivery Plan and develop a Cancer Delivery Programme by the end of March 2017, using the Capita cancer demand/capacity report.	Q3					track and focus at a time where leave and emergency pressures have been demanding for operational teams. Units have been asked to note this as a risk and seek more resilience and solutions. The reported January position shows that we delivered 24 breaches which should have given us performance of 81% if we had delivered the usual volumes. However again, activity appears to be below average with only have 116 confirmed new malignancies treated and therefore we delivered 79% against a trajectory of 87%. The reported February position shows that we delivered 21 breaches with 121 new malignancies treated, therefore we delivered 83% against a trajectory of 89%. To date performance is indicated to be lower than trajectory, with **17** known breaches. Based on usual activity this would equate to an end of month performance of **85%** Breast, Gynaecological, Urological and Lower GI are the top four tumour sites across the HB for breaches and account for 68% of all breaches between April 2017 and March 2018 . The Health Board have made it clear that it is a clear priority to recover of Cancer performance back to the improvement trajectory which it had delivered until December last year. This will regain confidence for the Board and WG around the potential for the Health Board to deliver more widely across other performance targets. Unit Directors have accordingly revisited their delivery plans within each of their teams. The Units have been asked to commit to returning to the expected trajectory towards 90% by the end of Quarter 1, and describe specific actions for both mitigation of risk and step change in performance at a tumour site level.	Achieve 90% compliance with USC cancer target	88%
	47	Review business case and, if supported, implement plan to centralise all breast services at NPTH, within resources.	Q3					• Uncertainty regarding progression of business case in light of potential boundary changes. • In the meantime a number of clinics have already moved from POWH to NPTH.	Business case developed.	POW Clinics start in NPT on 01/05/18 and will run as one stop clinic. Full centralisation of all clinics from singleton to NPTH no longer in plan
	48	Implement the outcomes of the commissioning review of Upper GI cancer surgery	Q3					Report (Dec 17) confirms two site model of OG service with option of SW Wales OG service Planning Lead appointed to lead service plan development Mtg Hywel Dda clinical leads took place in March 2018 Draft operational plan by the 1st May 2018	Sustainable service model	
	49	Continue Lin Acc replacement programme	Q1-Q4					• First patients seen on Lin Acc A March 2018 and machine now fully operational. • BJC completed and to be reviewed by the Investment and Benefits Group on the 24th April 2018 before being reviewed by the Board and submitted to Welsh Government.	Work progressing on Lin Acc A. Complete business case for Lin Acc B by March 2018.	
	50	Formally signal intention to WHSSC to develop PET-CT for the South-West Wales population through ARCH	Q1					• Aspiration outlined in ARCH South West Wales Non-Surgical Cancer Strategy which was approved at November Board (held in December).	Diagnostic waiting times delivered once PET-CT in place	

Actions and timescale								Impact Measurement	
Corporate Priority	Action		Timescale	Progress Q1	Progress Q2	Progress Q3	Progress Q4	Quarterly commentary on progress	Measure	Current position where numerical measures available *(Qtr 4)*
	51	Implement recommendations of the external review of thoracic surgery	Q1 & Q3					• Thoracic Surgery Implementation Group operational – jointly chaired by Morriston Hospital Unit Medical Director and Unit Service Director. • Three workstreams identified to support delivery of the action plan: o Clinical Processes & Pathways – led by Clinical Lead o Service Planning & Evaluation – led by Assistant Unit Service Director o Lung Cancer Site Specific – led by ABMU Lead Cancer Clinician. •Action plan updates in place and RAG rated • Key issues achieved to date include, thoracic nurse specialist, establishment and commencement of OD programme, revisions to theatre operating capacity, collaboration with the review of the future of thoracic surgery, confirmation or pre-hub funding to maintain enhanced service	Action plan to enable improved equity of access to resections for ABMU residents. New WHSSC Service Specification implemented.	
	52	Implement WHSSC-funded increase in thoracic surgery	Q1					• Prehab service which ensures patients' fitness for surgery implemented and funding confirmed for 18/19 • Service is delivering in excess of commissioned activity levels. • Resection rates have improved in line with required target of 20%	Number of lung cancer resections undertaken in ABMUHB	421 in 2016/17
	53	Implement WHSSC-funded increase in BMT	Q2					• BMT service has been unable to increase activity as planned due to inability to recruit to the nursing posts required to enable the increase.	Number of autologous BMTs undertaken in ABMUHB	30 undertaken in 16/17. 9 undertaken in Q1 17/18. Anticipated to treat 31 patients in year 2017-2018. Nurse
	54	Develop a plan to use the Tenovus Mobile Unit to increase capacity for chemotherapy (if revenue neutral)	Q1					• Option suspended in favour of alternative options for capacity • Pursuing home delivery opportunities which are anticipated to deliver faster results in alleviating capacity and also achieve VAT savings. Aim to implement November 2017.	Reduction in waiting time for chemotherapy from current wait of 31 days.	Waits are 5 weeks at end Q1. Tenovus mobile unit is now used 2 Saturdays per month. Waiting times are now 2 - 3 weeks depending on the number of hours required to deliver treatment. 2 weeks for shorter duration, 3 weeks for 6 hours plus.

Actions and timescale									Impact Measurement	
Corporate Priority		Action	Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures available *(Qtr 4)*
	55	Re-provide the Aseptic Unit at Singleton (pending move to Morriston as part of ARCH)	Q3					• Existing Aseptic Suite at Singleton has been extended and upgraded. • Contractors handed over new facility November 2017 • Pharmacy commissioning started January 2018 and is on-going, expected completion of commissioning for section 10 preparation of chemotherapy and PN is June 2018 and for MS manufacture of medicines is December 2018 • MHRA to inspect the Unit before deciding to award a Licence and application is likely to be submitted July 2018 once majority of internal commissioning is completed.	Audit of standards and demand.	
	57	Implement the priorities from the National Delivery Plans:								
		Cancer Delivery Plan	Q4					Detail is provided within each plan. A RAG assessment has been made on plan status.	See NHS Planning Framework 2017/18	As per RAG rating
		Critically Ill Delivery Plan	Q4							
		Diabetes Delivery Plan	Q4							
		Eye Health Care Delivery Plan	Q4							
		Heart Disease Delivery Plan	Q4							
		Liver Disease Delivery Plan	Q4							
		Mental Health Delivery Plan	Q4							
		Neurological Conditions Delivery Plan	Q4							
		Oral Health Delivery Plan	Q4							
		Organ Donation Delivery Plan	Q4							
		Palliative and End of Life Care Delivery Plan	Q4							
		Primary Care Delivery Plan	Q4							
		Rare Diseases Delivery Plan	Q4							
		Respiratory Health Delivery Plan	Q4							
		Stroke Care Plan	Q4							
Corporate Objective 3- Demonstrating Value and Sustainability										
		Workforce	See actions in Corporate Objective 4 – Securing a fully engaged and skilled workforce							
	58	Supporting actions outlined in Corporate Objective 4 regarding reducing dependence on variable pay.						See section 4.		
		Unwarranted Clinical Variation	Q3					• A application and dashboard demonstrating variation at consultant, specialty and unit level has been created to support prioritisation of action within each unit • UMDs have shared relevant NICE Do Not Dos with clinical leads and asked for confirmation they are not being done • UMDs have been asked to review INNU activity to see if it meets the inclusion criteria		
	59	Reduce unwarranted clinical variation							Measures in development	

Actions and timescale								Impact Measurement	
Corporate Priority	Action	Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures available *(Qtr 4)*
	Service Optimisation								
	i. Theatres	Q1					• Executive led focus on improving theatre productivity with Unit led action plans underpinning continue with some progress noted • Theatre capacity has been remodelled for Q4 to increase CEPOD/trauma provision and changes to previous main theatre sessions moving to day surgery as part of the plan to further improve compliance with the British Association of Day Surgery benchmarked performance • HB wide agreement on definitions to ensure status reporting is consistent and accurate. Further progress on preassessment screening in POW with Gynaecology and Upper GI now benefitting from freed up face to face preassessment slots		
60	Improve theatre productivity including reducing DNAs through text messaging, optimum use of lists, consolidation of lists, reduce number of cancellations, validation.							Reduction in surgical DNAs	Dec-16 compared with Dec-17: 0.3% reduction (7.0% to 6.7%)
								Improved theatre utilisation (time)	Mar 18 compared with Mar-17: Theatre utilisation rates reduced by 3% (73% to 70%)
	ii. Outpatients	See planned care section							
61	Supporting actions in planned care section to transform outpatients through reducing DNAs and follow-ups and validation						• Health Board wide Outpatient Transformation Workstream overseeing delivery units plans to reduce DNAs and address follow ups (the latter in accordance with recommendations from the Welsh Audit Office). • Delivery Units have been requested to develop and submit plans to deliver best in class DNA benchmark targets and plans to delivery the IMTP Delayed FUNB profile, providing assurance that patients are not coming to harm. Not all received. • Delivery Units undertaking review and monitoring of delayed FUNB categories A* and A to ensure patients are seen in a timely manner and if not are escalated accordingly.		
	iii. Length of Stay						• Executive led patient flow workstream in place to support ongoing work within the Service Delivery units on the implementation of SAFER flow bundles. Focus on: *Red to Green days *Estimated Date of Discharge * Increased number of patients discharge home before lunch * Reduction in bed days lost due to stranded patients * Increasing communication and awareness of the impact of delayed discharge on patient outcomes (deconditioning).	Reduction in LoS	
62	Reduce length of stay through reducing medically fit for discharge delays, delays in inter-hospital transfers, improving flow and discharges earlier in the day, reviewing function and use of community hospitals. Also supporting the work outlined in in unscheduled care section regarding community services and intermediate care.							Reduction in patients medically fit for discharge	Mar-17 compared with Mar-18 Discharge Fit: Morr increased by 17%
								Reduction in delayed inter-hospital transfers	Mar-17 compared with Mar-18: Morriston inter-hospital delays decreased from
	Digital Enablement	Q4					See action 13.		
63	Achieve target for e-TOC as outlined in Corporate Objective 2, and implement the agreed digital programme for 2017/18.							See Corporate Objective 2 -Quality Plan (70% compliance with e-TOC)	
	Medicines Optimisation						• Spend and clinical variation are closely monitored via primary care prescribing data • An action plan has been developed and is regularly reviewed and updated for new opportunities with progress regularly monitored • Target areas include national prescribing indicators, price concessions, respiratory, pain, medicines of low value etc.	Reduction in spend on medicines	Primary Care 12 month rolling cost (M) increased by 1.94% (Jan 17-Jan 18)

Actions and timescale									Impact Measurement	
Corporate Priority		Action	Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures available *(Qtr 4)*
Accelerate the work of the Recovery and Sustainability Programme to reduce the financial deficit of the Health Board by the end of 2017/18, with external support.	64	Ensure spend on medicines is clinically appropriate and develop an action plan to reduce unwarranted variation in prescribing.	Q2						Reduction in unwarranted variation in prescribing practice	Practice variation across ABMU has reduced in 11 out of 14 of the National Prescribing Indicators comparing 2015-2018
	65	**Estate rationalisation/back office functions** Reduce spend on management costs and corporate functions, rationalise the estate where possible, reduce rental payments.	Q2					• A&C total spend is less than same period previous year • Fairwood Hospital being marketed, offers to be submitted by 26th April 2018. HB to be asked to declare Coelbren Health Centre surplus to requirements in May 2018. • WAST have confirmed their interest in leasing the 2nd Floor of One Talbot gateway. Negotiations underway on terms. Design underway on internal fit out works.	Reduction in management costs Reduction in room hire and hospitality costs Reduction in rental payments Reduction in Health Board estates footprint	
	66	**Clinical Sustainability Models** Develop a Clinical Services Strategy for POWH with options which will clarify the future service model and relationships with other hospitals	Q3-Q4					• Clinical strategy options developed and scoped. • Focus is on ensuring POW alignment with South East regional delivery and planning opportunities via SE RPDF ● Work on hold pending consultation on Bridgend boundary change	Reduction in length of stay associated with inter hospital transfers Reduction in cost of medical rotas / locum spend	Mar-17 compared with Mar-18: Morriston inter-hospital delays decreased from 13 to 9 (-31%)
		Centralise urology at Morriston	Q3-Q4					• Internal networked plan agreed between POWH and Morriston Hospital - on hold due to consultation on future of Bridgend locality		
		Ensure the function, cost and efficiency of our community hospitals are maximised	Q3-Q4					• Throughput has increased through both Gorseinon and Maesteg hospital. Roles being reviewed as part of capacity redesign workstream (Recovery and Sustainability).		
		Make recommendations to improve the sustainability of vulnerable medical rotas	Q3-Q4					• Participate in international recruitment to alleviate recruitment difficulties • Participation in BAPIO to establish a new pipeline of doctors in training. • Wholescale review of junior doctor rotas to see if they can be redesigned to lessen reliance on locum cover. • Trialling new rota design which is more flexible but will have built in cover whilst meeting the educational requirements from the Deanery • Agency cap from the 1st November may encourage some locums to join the NHS as substantive doctors. • Role redesign and new roles ego advanced practice and roles such as Physician Associates.	Better fill rates	

Actions and timescale									Impact Measurement	
Corporate Priority		Action	Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures available *(Qtr 4)*
		Confirm the plans for the future of the Cefn Coed site	Q3-Q4					• New option appraisal for the future location of adult assessment beds across the ABMU area carried out – included in Mental Health Strategic Framework described above, approved by Board and RPB in November 2017. • Use of remaining buildings reviewed and rationalised, vacated areas emptied, services disconnected and secured. Business case being developed. Modelling work being commissioned to support business case	Agreement of plans for Cefn Coed site	
		Maximise the effectiveness of our IVF model	Q3-Q4					• Positive pregnancy cycle rates have increased although Neath is higher than Cardiff. Project closure report agreed by Executive Team following external reviews in 2016. Last quarter pregnancy outcome results increased across both units to national average, both units now have equal results. WHSSC contracted level of cycle achieved which is first time in many years.	Measure pregnancy outcomes on quarterly basis. Monitor activity levels monthly	Positive pregnancy outcomes increased for both centres in last quarter. WHSSC activity contract - on target to
	67	**Procurement/Consumables**							Reduction in spend on prostheses	
		Reduce total spend and variation by rationalising prosthesis and consumables spend across multiple suppliers	Q1					Total spend on medical/surgical consumables= £50 million, The expected reduction in spend FY18/19= £3 million= The areas of savings have been identified and agreed. Clinically led reduction in supplier variance, Work has commenced in all SDU's	Reduction in spend on consumables	6% decrease in spend of clinical/surgical spend standardised for activity by April 19- On track
Develop an IMTP for 2018-22 that is sustainable from a service, workforce and financial perspective	68	An integrated three-year plan for high-quality sustainable services within an approvable revenue envelope to be developed.	Q4					- Developed an integrated Annual Plan as agreed by the Board • Plan submitted to WG following Board approval in March	Agreement that a 3-year plan can be submitted to Welsh Government meeting their planning guidance requirements. (Note: approval may not be in 2017/18 year)	
Review developments made through investment and badged funding in last two years to examine if benefits achieved or monies can be re-directed or saved	69	Implement a review process to quantify the benefits and make recommendations on developments made through: ICF monies Mental health monies CAMHS monies Cluster funds Pacesetters IMTP development money	Q1					• Review of impact of ICF funding commissioned by Western Bay but primarily qualitative • All investments now subject to approval and scrutiny by Investment and Benefit group –established August 2017	Recommendations made on whether schemes remain or monies are re-directed	
	70	Develop a Primary and Community Services Strategy which will set out a sustainable approach to strengthening primary and community services and delivering more care closer to home	Q1					• Following a series of engagement workshops, a 5 year Primary and Community Services Strategy has been developed and was presented and accepted at the Health Board end of May 2017. • The Strategy sets out a sustainable approach to strengthening primary and community services and delivering more care closer to home. • Q4 work is progressed, again through a series of stakeholder workshops, to develop a prioritised implementation plan for the strategy to feed into the IMTP for 2018/19 and beyond.	Strategy published	Strategy approved

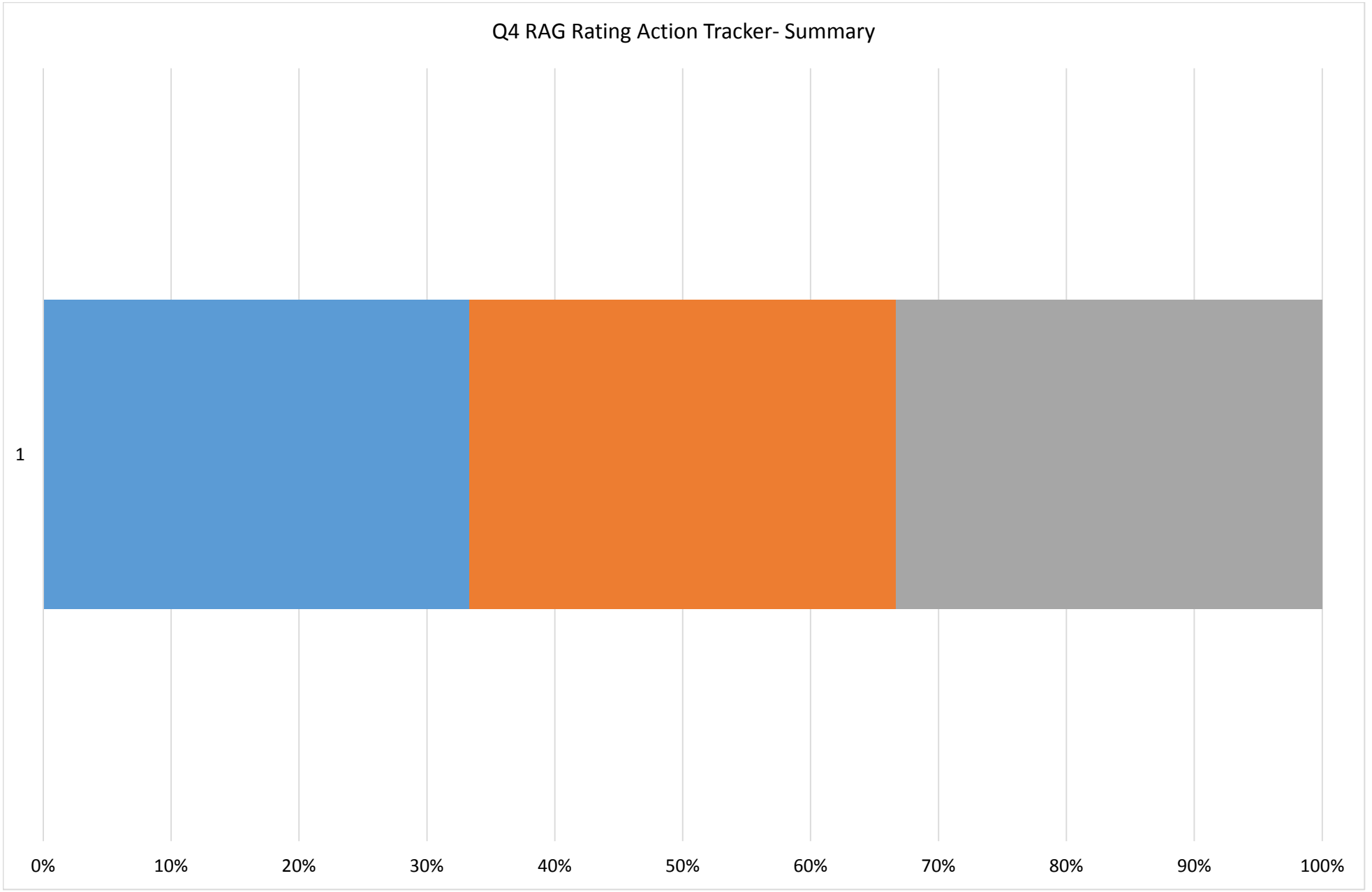
Actions and timescale									Impact Measurement	
Corporate Priority	Action		Timescale	Progress				Quarterly commentary on progress	Measure	Current position where numerical measures available *(Qtr 4)*
				Q1	Q2	Q3	Q4			
Continue to implement the sustainable service strategies and plans to deliver the health Board's strategic direction set out in Changing for the Better	71	Develop a Clinical Services Strategy for POWH with options which will clarify the future service model and relationships with other hospitals	Q1					• Clinical strategy options developed and scoped. • Focus is on ensuring POW alignment with South East regional delivery and planning opportunities via SE RPDF ● Implementation on hold pending results of consultation on Bridgend boundary change	Strategy published	Clinical strategy options developed
	72	Develop a short to medium term plan for Morriston Hospital to enable it to maximise its capacity and performance as part of the Health Board system.	Q2					• The role of Morriston Hospital as a level 4 hospital as part of the ABMU and wider South Wales healthcare system has been clearly set out. • The capacity required to enable this has been set out, and business cases to support this are nearing completion – e.g. Elective Orthopaedic Unit, additional temporary ward, use of therapy template for additional capacity, diagnostic capacity and Infrastructure Modernisation • Plans to progress priorities in ARCH and City Deal underway	Plan published	In progress
	73	Develop strategic frameworks for Mental Health/Learning Disabilities/CAMHS services	Q4					• Draft Strategic Framework for Adult Mental Health taken to Board in December 2017. • Workshop in October jointly between ABMU, C&V and CT Health Boards to agree strategic way forward for Learning Disabilities services, which is likely to involve development of strategic framework and implementation plan. • Delivery Plan developed for CAMHS.	Strategic Frameworks published	Final version to be taken to Board in May 2017
Implement the ARCH PDP when approved by Welsh Government	74	Implement Year 1 ARCH priorities	Q1-Q4					• Actions focussed on developing regional service models, creating wellbeing centres in Swansea and Bridgend and ILS developments in Singleton and Morriston • Continuing to progress within the resources available. • ILS/HTC developments being progressed through City Deal. • Clear work programme based on prioritisation for service transformation programmes, with short term priorities feeding into Joint Regional Planning	Sustainable models of care across region	

Actions and timescale								Impact Measurement	
Corporate Priority		Action	Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures available *(Qtr 4)*
Corporate Objective 4 - Securing a Fully Engaged and Skilled Workforce										
Have a fully engaged and skilled workforce fully committed to our corporate values	75	Implement the staff experience strategy and action plan and local and Health-Board wide recognition schemes	Q1-Q4					• Behavioural Leadership Programme 'Footprints' continues to be rolled out extensively across the Health Board. Since its launch in April 2017, a total of 24 cohorts have been delivered, with a total of 350 managers attending. The success and impact of the programme has led to development of Phase 2 from August 2018 and events are planned to review momentum of Phase 1 participants through 1st birthday celebrations in May 2018. Phase 2 will focus on a pilot with 8a managers within Mental Health and Learning Disabilities Delivery Unit. • Staff Listening in Estates is underway, including 18 facilitated listening sessions, team development and feedback. Training for facilitators took place in January 2018 and roll out of listening events began in February 2018. Listening sessions are now complete, reaching over 100 staff at all levels and in all sites. Thematic analysis is now complete and action planning sessions are on-going. • A series of clinical engagement conferences are taking place throughout 2018. This includes AHP Conference in February, Nursing Conference and an Inaugural Medical Engagement Conference in May. •NHS@70 celebrations underway including creation of memory book, unveiling of a statue, music festival planned and bunting creation along with chair's challenge lamp relay. Chairman's Staff Awards 2018 launched. Over 200 nominations received against 10 categories. Shortlisting complete and over 1700 votes counted. Filming for awards is complete and awards evening planned for 5th July. Long Service Awards planned for October 2018 and Patient Choice Awards planned for December 2018.	Bi-annual improvement in the percentage of staff who feel engaged.	Staff engagement score improved from 3.48 in 2013 to 3.68 in 2016
	76	Develop a proactive and comprehensive recruitment and retention plan that maximises fill rates for substantive roles and reduced reliance on agency and locum staff	Q4					• Continued overseas recruitment e.g. BAPIO and Philippines. • Continued Health Board open days for nurse recruitment • Implemented values based recruitment in mental health for HCSWs • Vacancy management and control systems in place to scrutinise and monitor	Reduction in current vacancies by 10%. Reduction in turnover by 10%. Reduction in bank and agency usage of 10%.	 1% increase between Dec-16 and Dec-17 (£2.162m to £2.188m)
	77	Address key workforce deficits in nursing through a review of Band 2, 3 and 4 roles	Q4					• Band 2 Healthcare support workers are being developed in line with the All Wales HCSW framework to develop their competencies to undertake observations for example. • Supporting HCSW to undertake level 4 CQFW over 2 years, which allows HCSW to apply to join nurse training from year 2 onwards. • Development of band 3 and 4 HCSW roles in community Paediatrics and Neonates to increase their competencies as an example. •15 HCSW Apprentices appointed in Morriston SDU working towards level 2 in HCS. 6 successfully appointed into Band 2 HCSW roles and moving on to level 3 study.	Increased number of staff employed in band 3 and 4 roles.	Band 2 & 4 has increased and band 3 has decreased
	78	Support managers to manage performance effectively through leadership and management training.	Q1-Q4					• Continued focus on values-based behavioural leadership and managing performance through roll out of 'Footprints' programme. Initial focus on bands 4-7 supervisory level. over 300 staff have completed the programme since April 2017 . • Over 60 attendees on Action Steps (action Learning programme) which looks at real life situations to develop leadership and management skills.	Contributes towards sickness, turnover, bank/agency and staff engagement targets.	

Actions and timescale								Impact Measurement	
Corporate Priority		Action	Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures available *(Qtr 4)*
		Improve performance in:								
	79	Sickness absence	Q4					• Sickness absence - The 12 month rolling performance to the end of March 17 is 5.74% and represents an overall decline in performance of 0.04% since the beginning of 2017/18. This is off of our planned IMTP trajectory by 0.60%. • Standardised process and methodology for LTS scrutiny being piloted. • Continuing to conducting a directed approach to the management of LTS by focussing efforts on the top 10 worst LTS cases in each unit on a periodic basis via the HR teams in each unit. • Resource has been identified to scan the Health Board's Occupational Health records and a procurement framework is being developed to identify a service provider. It is anticipated that the service will be a fully digital by December 2018 which will aid in reducing process inefficiencies and reduce waiting times. • Training for managers in recognising and managing common mental health problems at work and using HSE Stress Management standards has commenced. It is anticipated that these modules will contribute to managers being able to identify common mental health problems in the workplace and provide early intervention and support in the workplace.	Reduction of 0.5% in year.	5.74% in March 18 (increase of 0.04%)
		PADR compliance	Q4					• PADR compliance is 61.46%, this demonstrates an improving position from 54.40% in April 2017, although still below the WG target of 85%. • All Units restated target of 85% and this is monitored through Performance Review and endorsed by Internal Audit • Group PADRs continuing to be trained and roll out when requested, currently being considered to be added into updated policy.	85% compliance.	63.95%
		Mandatory and statutory training	Q4					• Mandatory and statutory training compliance against the 10 core competencies plus 3 ABMU specific policies 52.87% as at 31.03.2018 This figure has improved from 38.10% since April 2017. • All data has now been uploaded from Learn@NHSWales. • Data has identified that the lowest compliance area is Medical Dental with 21% compliance - an action is being considered around updating of records where higher level competence is required. • Individual updating and overriding of incorrect data continues with around 121 outstanding requests • Enabling resuscitation records to be updated on ESR records without double entry has begun with uploading of 2016 data • Continue to deliver face to face support for e-learning to support shift in cultural change. E Learning Support Sessions are running monthly with increased attendance.	85% compliance.	51.02%

Actions and timescale									Impact Measurement	
Corporate Priority		Action	Timescale	Progress Q1	Q2	Q3	Q4	Quarterly commentary on progress	Measure	Current position where numerical measures available *(Qtr 4)*
Corporate Objective 5 - Embedding Effective Governance and Partnerships										
Provide effective governance and assurance arrangements and continue to develop strong partnerships to improve services and outcomes	80	Implement the actions associated with the Health Board's targeted intervention status to address concerns through open and transparent dialogue with Welsh Government	Q4					• Performance and Finance Committee and meetings are held monthly and key focus is on the targeted intervention areas • Recovery and Sustainability Programme has been refreshed and areas of focus agreed for 2018/19 • Regular meetings held with Welsh Government to discuss progress • Maintained Targeted Intervention status • Review of Governance arrangements has been undertaken	Removal of targeted intervention	Review of targeted intervention status in October 2017
	81	Implement improved internal financial performance and accountability arrangements and transparency of decision-making to ensure agreed financial targets are delivered	Q1					• Performance and Finance Committee, and Investment and Benefits Group established • Improvements to transparency and accessibility and substance (forecasting and risk assessment) of Financial Performance Reporting, including savings plans for Recovery & Sustainability Governance purposes, using data visualisation techniques to support management and Board decision making • Unit (and Corp) pay and non-pay run rates targets to be issued following confirmation of RTT delivery agreement. Monitoring via weekly financial performance dashboard with management action and escalation process • Actions being implemented in response to external financial governance review	Delivery of agreed financial targets	Year End overspend of £29.8m overspend against a target profile of £20m
									Full identification of savings requirements	£25m savings requirement full identified, however some slippage against planned savings delivery
	82	Developing and implementing plans to secure long term sustainable change through our statutory partnerships including the Western Bay Regional partnership Board and Public Service Boards	Q1-Q4					• Western Bay Area Plan agreed at Health Board in March 2018 • PSB Wellbeing Plans for ICF have been agreed through an inclusive process • Specification for a pooled fund for care home accommodation in development. • Positive external evaluation of Community Resource Team funded by ICF	Improved performance through integrated teams.	
									Pressures on adult social care understood and plans in place to support care across system.	
									Further pooled budgets established where appropriate.	
									Needs and Wellbeing Assessments used to inform plan development	
	83	Ensure that commissioned services reflect the needs of our population	Q1-Q4					• 2013/14 Population needs assessment refreshed 2015/16. SSWB and WBFGA assessments being used to inform clinical strategy and 2018/19 plan. • Service change priorities reflect needs assessment, e.g. Rapid Diagnosis Clinic, Diabetes and Respiratory pathways. • Adult Mental Health Strategic Commissioning Framework to Board in November 2017 & joint work with other Health Boards on Learning Disabilities services underpinned by needs assessment • ABMU developed Wellbeing Plans with Public Service Boards (and leading priority workstreams, e.g. Wellbeing in Workplace; Early Years) and Area Plan for Western Bay.	Improved performance to meet WG targets with commissioned services reflecting population need.	

Actions and timescale									Impact Measurement	
Corporate Priority	Action		Timescale	Progress				Quarterly commentary on progress	Measure	Current position where numerical measures available *(Qtr 4)*
				Q1	Q2	Q3	Q4			
	84	Ensure our capital programme supports the delivery of sustainable services	Q1-Q4					• 3 Business cases, including the ARCH PDP, currently with WG awaiting comments. * ARCH * Transitional Care Unit (Singleton Neonatal) * Clinical Digital Records Management System • Work is proceeding on 6 projects with approved Business cases. • 10 Business cases are being developed with plans to develop a further 8 already being investigated. • In addition there are a number of Informatics Business cares that are being developed for submission to WG.	Business cases delivered and approved to support improved quality of care and performance	
	85	Develop an Organisational Strategy to align all of our existing strategies providing a coherent and consistent organisational direction	Q2					• Health Board has considered how to take this work forward. Executive Team have decided that initial priority is to update Clinical Strategy by the summer of 2018 with the Organisational Strategy to follow.	Health Board has clear strategic direction across all elements of responsibility – clinical/quality/workforce etc. to support improved performance.	


Q4 RAG Rating Action Tracker- Summary
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40%
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60%
70%
80%
90%
100%

Q4 Actions Tracker- Promoting and Enabling Healthier Communities

Q4 Actions Tracker- Delivering Excellent Patient Outcomes, Experience and Access

Q4 Actions Tracker- Demonstrating Value and Sustainability

Q4 Actions Tracker- Securing a Fully Engaged and Skilled Workforce

Q4 Actions Tracker- Embedding Effective Governance and Partnerships