Quality and Safety Urgent Action Log

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1.	174/19	12.12.2019	Update be provided in respect of Suicide Prevention Report	KR	August 2020	On the work programme
Closed Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
	-		Nil Return.	-	-	-

Quality and Safety Pending Action Log

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
2.	121/19	22.08.2019	Update be provided on the improved use of ward to board dashboard following feedback from staff.	GH/ CWilliams	August 2020	On the work programme
3.	158/19	24.10.19	Update be provided in respect of the older people's strategy.	NJ	October 2020	On the work programme
4.	175/19	12.12.2019	Update be provided in respect of Substance Misuse Report	KR	September 2020	On the work programme
5.	17/20	28.01.2020	Deep Dive: Never Event position and the requirement to review and manage overarching improvement plan at corporate level to be brought to committee.	HL	September 2020	To be delayed as a result of COVID19
6.	12/20	28.01.2020	Report and action plan in respect of the facilities at Morriston Hospital's Accident and Emergency Department be brought to February's committee.	Craige Wilson/ Deb Lewis	September 2020	To be delayed as a result of COVID19

7.	42/20	25.02.2020	Quality and Safety Workshop 2020 to be arranged and the Quality and Safety Bill and duty of candour is incorporated into the workshop.	GH/ CWilliams	September 2020	To be delayed as a result of COVID19
8.	87/20	12.12.2019	Feedback from patients within a prison setting to be included within the patient experience report.	HL	August 2020	To be delayed as a result of COVID19
9.	87/20	24.03.2020	Discussion to take place to ascertain how to include the internal inspections within the performance figures.	GH/ CWilliams	July 2020	To be delayed as a result of COVID19
10.	107/20	26.05.2020	Screen shots of the dashboard to be provided to independent members.	MJ/MW	June 2020	Work is ongoing to give the independent members access to the dashboard itself.
11.	133/20	23.06.2020	Performance team to obtain and report the Primary Care metrics within the performance report.	DG/SHG	August 2020	On the work programme.
12.	133/20	23.06.2020	Patient referral concerns to be raised to the Health Minister.	MW	July 2020	Communication to patients of accessibility to services is a priority for Welsh Government.

Closed Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
13.	47/20	25.02.2020	Update be provided as to how quickly other organisations' recruitment processes are against the health board.	CWhite	September 2020	Referred to WOD Committee. Director of Workforce and OD confirmed that this had previously been discussed at WOD. Completed.
14.	169/19	12.12.2019	Update be provided in respect of Paediatric Acute and Emergency Report	CD	July 2020	Referred to Quality and Safety Governance Group for monitoring. Completed.

Quality and Safety Workshop Pending Action Log

Wednesday, 9th October 2019 in the Millennium Room, HQ

Present:
In attendance: Martyn Waygood (chair); Gareth Howells; Pam Wenger; Darren Griffiths; Chris White; Richard Evans; Cathy Dowling; Hazel Lloyd; Helen Kemp; Paul O'Connor; Lesley Jenkins; Tanya Spriggs; Hannah Roan; Reena Owen; Maggie Berry; Christine Williams; Jackie Davies; Keith Reid; Kay Myatt; Craig Barker; Leah Joseph (notes).

Agenda Item	Comments/Action	Lead for Action	Progress	Timescale
Apologies for absence	Apologies for absence were noted from: - Matt John; - Lee Morgan; - Alastair Roeves.			
	Patient Experience – Reporting for the committee needs to be more reactive and duplication of reports in separate committees needs to be minimised. Community services need a sharper focus for board and all committees. Reena Owen queried if the committee knows how well the safety considerations on waiting lists is being collected. Comments were made to possibly enhance the way we obtain patient feedback. An electronic short survey could be an option, similar to the software NHS England uses. If			

	this is successful, the health board will need to agree how to manage patient information when received. Craig Parker is working with PROMS for text reminders to include appointment information and updates, at ward and patient level to ensure it is user friendly depending on patient's additional needs. Paula O'Connor highlighted that the health board need to align themselves and measure against the health and care standards. Following the meeting, Martyn Waygood mentioned that the committee needs to monitor the implementation of recommendations which includes internal audit reports, HIW and delivery unit reports when they have a Quality and Safety aspect. The Committee needs to seek to standardise the actions and implementations following such audits and inspections. In addition we need to record and act upon staff feedback and patient safety walk rounds. **Action: The "So What?" approach may be included going forward in respect of complaints. Knowing the impact on patients when they are cancelled or a breach. How does it feel to be a breach or to be cancelled?** **Action: The performance team consider utilising the efficiency framework toolkit alongside the performance report.**	**HL/PW** **DG**		End of December End of December

	Action: Further guidance to be provided to authors for higher level training to understand the information received in papers to assist with assurance.	**ALL**		September
	Primary Care Metrics – Helen Kemp advised colleagues that artificial intelligence software relating to natural language processing is being utilised in the commercial sector which the NHS is not benefiting from. **Action: Martyn Waygood, Helen Kemp and Pamela Wenger to meet to discuss metrics.**	**MW/DG/HK**	Meeting has been cancelled and will be rescheduled sometime in 2020 due to COVID-19.	In Progress
	Serious Incidents and Never Events – Hazel Lloyd confirmed that SBUHB is the only health board in Wales that has a Serious Incident team, and the investigation toolkit is currently being rolled out. SBUHB reports are detailed, however the team are working towards an executive summary. Datix coding will be consistent in the future and the newsletter promotes incident reporting.			