ID	Goal	Method	Action	Assignee	Name	Start date	Due date	Last updated	Status	Dependent on	Desired outcome	Enablers
SRC101	**Learning from patient safety incidents**	We will review our processes for working with patients and their families when things go wrong, i.e. ensure that incidents involving the safety of our patients, complaints, mortality and morbidity reviews are joined up from the patient/family perspective and they have a key and clear point of contact.	Implementation of Duty of Candour	Assistant Head of Concerns	Sue Ford	01/04/2023	31/03/2024		On-track		Improved patient experience	Delivery of Duty of Candour
	Learning from patient safety incidents	We will review and strengthen our arrangements for learning from serious incidents.	Review of process and paper to PSC	Assistant Head of Concerns	Nicola Anthony	01/04/2023	31/03/2025		Not started		Improved organisational learning and patient safety	
	Learning from patient safety incidents	We will adopt an open 'no blame' approach to incident investigation and learning in order to achieve a more restorative approach to improvement	Review of process and paper to PSC	Assistant Head of Concerns	Nicola Anthony	01/04/2023	31/03/2025		Not started		improved organisational learning, patient safety and staff experience	
	Learning from patient safety incidents	We will contribute to national work to ensure that there are effective incident reporting systems in place for independent contractors	Contribution to and roll out of national system	Assistant Head of Risk and Assurance, CD Primary Care	Neil Thomas	01/04/2023	03/04/2024		Not started			
	Learning from patient safety incidents	We will continue to focus on encouraging incident reporting and systematic incident analysis, implementation of risk reduction actions	Timely management of incidents in line with HB process	Assistant Head of Risk and Assurance,	Neil Thomas	01/04/2024	31/03/2025		Not started		Timely learning from incidents in order to promote improved patient safety	
	Learning from patient safety incidents	We will review levels of reporting lower levels of harm and near misses and set target for increasing these rates in line with national profiles	Review of incidents against national profile, targetted programmes within areas of low incident reporting	Chair PSC Group	Heidi Maggs	01/04/2025	31/03/2026		Not started			
SRC102	**Preventing Peri-operative Never Events**	We will sustain 95 per cent compliance in the use of the WHO surgical safety checklist	Monitoring of WHO compliance through audit and incident review	Service group medical directors (Morriston, NPTSSG)	Mark Ramsey, Dougie Russel	01/04/2023	31/03/2024		On-track		Improved patient outcomes	
	Preventing Peri-operative Never Events	Zero peri-procedure never events for a year	Incident monitoring and audit	Assistant Head of concerns	Nicola Anthony	01/04/2024	31/03/2025		Not started		Improved patient outcomes	
SRC103	**Medicines safety including at the point transfer of care (medicines optimisation)**	We will set a target for the number of patients with complex medicines referred for a post discharge community pharmacy review	Target developped, method of measurement agreed, communication with Community Pharmacies	Head of Integrated Medicines Management and Head of Primary Care	Judith Vincent	01/04/2023	31/03/2024		Not started		Improved patient outcomes	
	Medicines safety including at the point transfer of care (medicines optimisation)	We will achieve the target we have set for post discharge community pharmacy review	Report to Medicines Management Board	Head of Primary Care	Judith Vincent	01/04/2024	31/03/2025		Not started		Improved patient outcomes	
	Medicines safety including at the point transfer of care (medicines optimisation)	"Get it on time"- develop an approach to ensure patients receive their Parkinson's medicines within 30 minutes of the prescribed time	Programme developped	Head of Integrated Medicines Management	Alan Clatworthy	01/04/2023	31/03/2024		On-track		Improved patient outcomes	
	Medicines safety including at the point transfer of care (medicines optimisation)	Deliver on Get it on Time	Programme delivered	Head of Integrated Medicines Management	Alan Clatworthy	01/04/2024	11/04/2025		Not started		Improved patient outcomes	
	Medicines safety including at the point transfer of care (medicines optimisation)	Zero medication incidents involving high risk medicines (such as insulin) resulting in moderate or severe harm	Development of local processes for gaining assurance within service groups	Service group nursing and medical directors	Judith Vincent	01/04/2024	31/03/205		Not started		Improved patient outcomes	
	Medicines safety including at the point transfer of care (medicines optimisation)	Utilisation of the electronic prescribing and medicines administration system to audit and improve the quality of medicines management across the Health Board.	Reporting into Medicines Management Board	Head of Integrated Medicines Management	Judith Vincent	01/04/2023	31/03/2025		On-track		Improved patient outcomes	
SRC104	**Understanding, measuring and reducing patient mortality**	We will identify the top ten casues of adult mortlaity; from this we will devleop learning to support and enhance our patietns safety and quality improvement programmes	Development of mortality action plan based on top 10 themes. Feedback from learning into Patient Safety Congress programme	Deputy Executive Medical Director	Raj Krishnan	01/04/2023	14/04/2024		On-track		Improved patient outcomes	
	Understanding, measuring and reducing patient mortality	Review our maternal and neo-natal mortality data and use this to develop a safety and quality improvement programme	Development of local processes for gaining assurance within service groups	Deputy Executive Medical Director	Raj Krishnan Sue Jose	01/04/2023	15/04/2024		On-track		Improved patient outcomes	
	Understanding, measuring and reducing patient mortality	Delivery of the maternal and neo-natal m ortlaity safety and quality improvement programme	Development of QI workstreams resulting from review of mortality information	Service group medical director, Deputy Head of Quality and Safety- Maternity and Neo-nates	Raj krishnan Sheena Morgan	01/04/2024	31/03/2025		Not started		Improved patient outcomes	
	Understanding, measuring and reducing patient mortality	Thematic review of deaths within mental health services	Review of deaths presented within service group	Medical director- MH and LD	Richard Maggs	01/04/2023	31/03/2024		Not started		Improved patient outcomes	
	Understanding, measuring and reducing patient mortality	Development of safety and improvement programme based on outcome of the review MH	Development and delivery of improvement programme	Medical director- MH and LD	Richard Maggs	01/04/2024	31/03/2025		Not started		Improved patient outcomes	
	Understanding, measuring and reducing patient mortality	Thematic review of deaths within learning disability services	Review of deaths presented within service group	Medical director- MH and LD	Richard Maggs	01/04/2023	19/04/2024		Not started		Improved patient outcomes	
	Understanding, measuring and reducing patient mortality	Development of safety and improvement programme based on outcome of the review LDis	Development and delivery of improvement programme	Medical director- MH and LD	Richard Maggs	01/04/2024	31/03/2025		Not started		Improved patient outcomes	
SRC105	**Improving outcomes and learning from National audits, registries, confidential enquiries and PROMs**	95 per cent of relevant published NICE guidance will be formally reviewed by the Health Board within 90 days of publication.	Process for review and disseminaion in place	Deputy Executive Medical Director	raj krishnan	01/04/2023	31/03/2024		Not started		Improved patient outcomes	
	Improving outcomes and learning from National audits, registries, confidential enquiries and PROMs	We will develop and implement new internal systems for identifying and monitoring compliance with national guidance	System developped	Deputy Executive Medical Director	raj krishan	01/04/2024	31/03/2025		Not started		Improved patient outcomes	
	Improving outcomes and learning from National audits, registries, confidential enquiries and PROMs	All clinical services (at sub-specialty level) will participate regularly in clinical audit (measured by registered clinical audit activity during each year of this strategy)	Audits completed and learning shared	Service group medical directors	Sharron Ragbetli	01/04/2023	31/03/2025		On-track		Increased assurance and learning	
SRC106	**Using data and benchmarking intelligence to understand variation in outcomes**	To develop a quality dashboard for the organisation and service groups that give people live access to the quality information they need	Development and launch of dashboard	Business Intelligence Partner	Dai Williams	01/04/2023	31/03/2024		On-track		increased use of data to support patient safety and outcomes	
	Using data and benchmarking intelligence to understand variation in outcomes	Review the current arrangements for the generation and reporting of quality, experience, outcome and effectiveness in order to provide reliable, accurate and timely information on the quality of our care	Review of quality measures across HB to support Duty of Quality	Head of Performance and Finance & Head of Quality and Safety	Angharad Higgins	01/04/2023	31/03/2025		On-track		Improced data quality to inform decision making	