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Bwrdd Iechyd Prifysgol  
Hywel Dda  
University Health Board

## Pwyllgor Ansawdd, Diogelwch a Phrofiad/ Quality, Safety and Experience Committee

|                                                  |                                                                                  |
|--------------------------------------------------|----------------------------------------------------------------------------------|
| <b>DYDDIAD Y CYFARFOD:<br/>DATE OF MEETING:</b>  | <b>08 OCTOBER 2026</b>                                                           |
| <b>TEITL YR ADRODDIAD:<br/>TITLE OF REPORT:</b>  | Hywel Dda University Health Board Patient Safety Plan 2026–2031                  |
| <b>CYFARWYDDWR ARWEINIOL:<br/>LEAD DIRECTOR:</b> | Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience     |
| <b>SWYDDOG ADRODD:<br/>REPORTING OFFICER:</b>    | Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding |

**Pwrpas yr Adroddiad** (dewiswch fel yn addas)

**Purpose of the Report** (select as appropriate)

Ar Gyfer Penderfyniad/ For Decision

### ADRODDIAD SCAA SBAR REPORT

#### Sefyllfa / Situation

The purpose of this paper is to share the Hywel Dda University Health Board Patient Safety Plan 2026–2031 with the Quality, Safety and Experience Committee (QSEC), provide assurance on its alignment with the National Patient Safety Plan for NHS Wales and the Health Board's Quality Management System, and seek the Committee's support for the proposed approach to implementation, oversight and assurance.

#### Cefndir / Background

This Patient Safety Plan sets out Hywel Dda University Health Board's local response to the [National Patient Safety Plan for NHS Wales 2026–2031](#). It translates the national ambition of listening, leading and learning for safer care into a local delivery framework across acute, community, primary care, mental health, women and children's services, commissioned services and partnerships. The plan uses the Health Board's Quality Management System to connect planning, improvement, control and assurance, ensuring that patient safety intelligence is identified early, acted on consistently, and reported with clear line of sight from services to Board.

The draft Patient Safety Plan was considered by the Formal Executive Team (FET) on 12 August 2026, where further clarification was requested on the local patient safety priorities and the proposed executive leadership arrangements. Further discussion on the plan was held on 16 September 2026.

#### Asesiad / Assessment

The Patient Safety Plan sets out the Health Board's local response to the National Patient Safety Plan for NHS Wales 2026–2031. It establishes patient safety as a whole-system organisational capability and uses the Quality Management System to connect planning,

improvement, control and assurance. This creates a clearer line of sight from frontline services and Clinical Care Groups to executive governance, QSEC and the Board.

The Plan adopts the seven national clinical safety priorities and identifies three additional local priorities: access, including service fragility; patient safety culture; and workforce and resource sustainability. These local priorities reflect the Health Board's intelligence on avoidable harm, experience, outcome variation, resilience and assurance, and ensure that access, operational pressure and resource constraints are recognised and managed where they create patient safety risk.

Delivery will be coordinated through the six national enabling functions of leadership, workforce, culture, information and insights, learning, improvement and research, and whole-system working. These will operate through existing programmes and governance arrangements rather than creating parallel structures. Overall accountability rests with the Executive Director of Nursing, Quality and Patient Experience, supported by relevant executive leads, named senior responsible owners and accountable Clinical Care Groups and functions. Detailed workstream leadership will be confirmed through Executive Team arrangements. Implementation will be phased, with foundations established during 2026–2027 and further enhancement and embedding through to 2031. QSIG will support oversight of integrated patient safety intelligence and delivery confidence, with progress and exceptions reported through executive governance to QSEC. Reporting will distinguish activity from impact and will include ownership, milestones, measures, risk and control position, dependencies, evidence gaps and assurance on whether outcomes are improving. QSEC's support will provide important committee-level endorsement of the strategic direction and the proposed governance and assurance approach.

The Plan will be supported by a dynamic Quality and Safety Position Statement that connects the Corporate Risk Register, operational risks, patient safety priorities, quality intelligence and organisational delivery arrangements. For QSEC, the Position Statement (narrated through the Quality Assurance Report) will provide a concise strategic view organised around the principal Board risks of Access, Fragile Services and Resource Sustainability. These will operate as cross-cutting lenses rather than additional programmes, enabling the Committee to consider where delayed or unreliable access is causing or transferring harm, where services may be unable to maintain safe and sustainable standards, and where workforce or financial constraints are affecting safety or limiting delivery of agreed controls.

The underlying delivery matrix will triangulate incidents and patient safety reviews; concerns, complaints, compliments and patient experience; mortality, clinical outcomes and avoidable harm; audit and regulatory findings; operational performance and access; workforce capacity, capability and staff experience; financial intelligence; corporate and operational risks; and evidence of improvement and control effectiveness. Evidence will be tested for alignment, contradiction, gaps and reliability. Reporting will distinguish fact, interpretation and executive judgement, and will record uncertainty where evidence is incomplete rather than provide false assurance.

To support effective scrutiny, the Position Statement will separate three judgements for each priority: the patient safety position, describing whether the underlying risk of harm is controlled or changing; delivery status, describing whether agreed actions and milestones are on track; and assurance confidence, describing whether the evidence is sufficiently timely, reliable and triangulated to support the reported judgement. The QSEC report will summarise the current position and direction of travel, principal concerns, evidence gaps, required decisions and any matters requiring escalation or formal risk consideration.

Clinical Care Groups and corporate functions will maintain local risks and controls, provide agreed evidence and measures, escalate deterioration and demonstrate whether actions are improving outcomes. The Quality and Safety Intelligence Group (QSIG) will act as custodian of the integrated matrix, triangulating intelligence and testing the reported position, trajectory and assurance confidence. The Formal Executive Team (FET) will consider material exceptions, cross-organisational trade-offs, resource dependencies and residual risks before onward reporting. QSEC will receive the consolidated Position Statement, scrutinise whether principal quality and patient safety risks are understood, effectively controlled and improving, and provide assurance to the Board. Significant deterioration or emerging harm will be escalated between routine reporting cycles.

### Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked to:

- Receive the Hywel Dda University Health Board Patient Safety Plan 2026–2031
- Support the Plan's strategic direction, including adoption of the seven national clinical safety priorities and the three additional local priorities of access, patient safety culture, and workforce and resource sustainability;
- Support implementation through the Health Board's Quality Management System and existing governance arrangements, with clear executive sponsorship, named accountability and Clinical Care Group delivery;
- Endorse the approach to developing a Quality and Safety Position Statement and integrated delivery matrix as the basis for routine QSEC reporting; support QSIG's role as custodian of the detailed intelligence and FET's role in considering material exceptions, resource decisions and residual risks; and agree that QSEC will scrutinise the consolidated position, direction of travel, delivery status, assurance confidence, evidence gaps and required escalation in order to provide assurance to the Board.

### **Amcanion: (rhaid cwblhau)**

#### **Objectives: (must be completed)**

|                                                                                                            |                                                                                                                                             |
|------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| Cyfeirnod Cylch Gorchwyl y Pwyllgor:<br><br>Committee ToR Reference:                                       | 2.1 provide the Board with assurance that care across the Health Board is safe, timely, efficient, effective, equitable and person-centred. |
| Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol:<br>Datix Risk Register Reference and Score:     |                                                                                                                                             |
| Parthau Ansawdd:<br>Domains of Quality<br><a href="#">Quality and Engagement Act (sharepoint.com)</a>      | 7. All apply                                                                                                                                |
| Galluogwyr Ansawdd:<br>Enablers of Quality:<br><a href="#">Quality and Engagement Act (sharepoint.com)</a> | 6. All Apply                                                                                                                                |

|                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                   |
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| Amcanion Strategol y BIP:<br>UHB Strategic Objectives:                                                                                                                                                                                                                                        | All Strategic Objectives are applicable                                                                                                                                                                                                                                                                                                                                           |
| Nodau Cynllunio 2026/27<br>Planning Goals 2026/27                                                                                                                                                                                                                                             | 6. Safe, Timely, High Quality Care                                                                                                                                                                                                                                                                                                                                                |
| <a href="#">Hypergyswllt i Amcanion Llesiant HDdUHB 2026</a><br><br><a href="#">Hyperlink to HDdUHB Well-being Objectives 2026</a>                                                                                                                                                            | 4. Create an inclusive culture where every voice matters, individual needs are considered and staff well-being is promoted and supported<br>5. Foster a learning culture by sharing knowledge and applying new ways of working that enhance local and global well-being<br>6. Work with partners and communities to nurture and support everyone to achieve their best well-being |
| <a href="#">Model Cymdeithasol ar gyfer lechyd a Llesiant:</a> (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau)<br><br><a href="#">A Social Model for Health and Wellbeing:</a> ( <i>complete for strategic change and/or significant service changes</i> ) | Not Applicable                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Gwybodaeth Ychwanegol:<br/>Further Information:</b>                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                   |
| Ar sail tystiolaeth:<br>Evidence Base:                                                                                                                                                                                                                                                        | <a href="#">National Patient Safety Plan for NHS Wales 2026–2031.</a>                                                                                                                                                                                                                                                                                                             |
| Rhestr Termau:<br>Glossary of Terms:                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                   |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn:<br>Parties / Committees consulted prior to this meeting:                                                                                                                                                                       | Formal Executive Team discussion in August and September 2026.                                                                                                                                                                                                                                                                                                                    |
| <b>Effaith: (rhaid cwblhau)<br/>Impact: (must be completed)</b>                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Ariannol / Gwerth am Arian:<br/>Financial / Service:</b>                                                                                                                                                                                                                                   | There are no immediate additional financial or capital requirements arising from this paper. Delivery of the Patient Safety Plan will need to be aligned to existing                                                                                                                                                                                                              |

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
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|                                                          | <p>organisational resources, with any specific financial implications identified through the relevant planning, prioritisation and business case processes as individual improvement actions are developed. Recognising workforce and resource sustainability as a local patient safety priority will support clearer understanding of the relationship between resources, service fragility, access and avoidable harm.</p>                                                                                                                                                                                                                                                                                                                                 |
| <b>Ansawdd / Gofal Claf:<br/>Quality / Patient Care:</b> | <p>The Patient Safety Plan is expected to have a positive impact on quality and patient care by strengthening the Health Board's approach to identifying, understanding and reducing avoidable harm. The inclusion of local priorities will support a clearer focus on the issues most relevant to Hywel Dda UHB, including access, service fragility, patient safety culture, workforce and resource sustainability. The proposed executive leadership model will support clearer ownership, escalation and assurance, helping to ensure that patient safety risks are acted on consistently and that learning is translated into improvement.</p>                                                                                                          |
| <b>Gweithlu:<br/>Workforce:</b>                          | <p>The Patient Safety Plan is expected to have a positive impact on the workforce by supporting clearer executive ownership of the workforce contribution to patient safety, including capability, education, role-based learning, staff experience and safety behaviours. It also recognises workforce and resource sustainability as a local patient safety priority, supporting more explicit consideration of the relationship between staffing, service fragility, access, staff wellbeing and avoidable harm. There are no immediate adverse workforce impacts arising from this paper; however, successful delivery will require alignment with existing workforce planning, organisational development and professional leadership arrangements.</p> |
| <b>Tegwch Iechyd:<br/>Health Equity:</b>                 | <p>The Patient Safety Plan is expected to have a positive impact on health equity by supporting a clearer understanding of variation in patient safety risks, outcomes and experience across services and populations. The inclusion of access, service fragility, workforce and resource sustainability as local patient safety priorities will help ensure that potential inequity in timely access to safe care is considered as part of prioritisation, escalation and assurance. An equity-focused health impact assessment has not been undertaken for this update, as the paper seeks agreement on the local priorities and executive leadership model rather than proposing a specific service change; however, equity considerations should</p>     |

|                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
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|                                  | be built into the delivery and monitoring of individual improvement actions.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Risg:<br/>Risk:</b>           | The paper supports a positive risk impact by strengthening the identification, ownership and escalation of patient safety risks through the Patient Safety Plan. The inclusion of local priorities, including access, service fragility, patient safety culture and workforce/resource sustainability, will support clearer alignment between operational risk, clinical risk and organisational assurance. The main risk is that, without clear executive ownership and delivery oversight, implementation may be inconsistent across services; this is mitigated through the proposed executive leadership model, alignment to the Quality Management System and reporting through existing governance routes, including QSEC and Board.             |
| <b>Cyfreithiol:<br/>Legal:</b>   | There are no immediate legal implications arising directly from this paper. The Patient Safety Plan supports the Health Board's statutory duties in relation to quality, safety, candour, concerns management and organisational accountability. Clearer executive ownership and assurance arrangements will support compliance with the Duty of Quality, Duty of Candour and wider requirements to identify, escalate and reduce avoidable harm. Any specific legal implications arising from individual improvement actions will be considered through the relevant governance, risk, policy or service change processes.                                                                                                                            |
| <b>Enw Da:<br/>Reputational:</b> | The Patient Safety Plan is expected to have a positive reputational impact by demonstrating that the Health Board is taking a structured, locally informed and executive-led approach to delivering the National Patient Safety Plan for NHS Wales. Clearer identification of local patient safety priorities, including access, service fragility, culture and workforce/resource sustainability, will support greater transparency, accountability and assurance. The main reputational risk would arise if delivery is not progressed consistently or if known patient safety risks are not demonstrably acted upon; this is mitigated through the proposed executive leadership model and existing governance routes for oversight and escalation. |

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|------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Gyfrinachedd:<br/>Privacy:</b>  | <p>There are no immediate privacy, confidentiality or information governance implications arising directly from this paper. The Patient Safety Plan does not propose the use or sharing of identifiable patient or staff information; however, delivery will rely on appropriate use of patient safety intelligence, incident data, concerns, complaints, audit and learning information. Any use of personal or sensitive information through individual improvement actions will be managed in line with existing information governance, confidentiality, data protection and records management requirements.</p>                                                                                                                                                                                                        |
| <b>Cydraddoldeb:<br/>Equality:</b> | <p>The Patient Safety Plan is expected to have a positive impact on equality by supporting a more consistent approach to identifying and responding to patient safety risks across services and populations. The inclusion of access, service fragility, patient safety culture and workforce/resource sustainability as local priorities will support consideration of whether particular groups may experience differential risk, poorer access, or variation in outcomes and experience. EqlA screening has not been undertaken for this update, as the paper seeks agreement on local priorities and executive leadership arrangements rather than proposing a specific service change; however, equality considerations should be built into delivery, monitoring and evaluation of individual improvement actions.</p> |

# Hywel Dda University Health Board Patient Safety Plan 2026–2031



|                                |                                                                            |
|--------------------------------|----------------------------------------------------------------------------|
| <b>Document owner</b>          | Executive Director of Nursing, Quality and Patient Experience              |
| <b>Lead author / portfolio</b> | Interim Assistant Director of Nursing, Assurance and Safeguarding          |
| <b>Status</b>                  | V1.2 (September 2026) – updated following Formal Executive Team discussion |

**Executive summary:** This Patient Safety Plan sets out Hywel Dda University Health Board's local response to the National Patient Safety Plan for NHS Wales 2026–2031. It translates the national ambition of listening, leading and learning for safer care into a local delivery framework across acute, community, primary care, mental health, women and children's services, commissioned services and partnerships. The Plan uses the Health Board's Quality Management System (QMS) to connect planning, improvement, control and assurance, so that patient safety intelligence is identified early, acted on consistently and reported with a clear line of sight from services to the Board.

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# 1. Purpose and ambition

Hywel Dda University Health Board's ambition is to reduce avoidable harm, strengthen safety culture and embed learning into everyday practice so that people across Carmarthenshire, Ceredigion and Pembrokeshire receive care that is safe, timely, effective, efficient, equitable and person-centred. The plan responds directly to the National Patient Safety Plan for NHS Wales 2026–2031 and aligns with the Duty of Quality, Duty of Candour, Health and Care Quality Standards, Listening to People guidance, the NHS Wales Quality Outcomes Framework and the emerging national Clinical Governance Framework.

The local approach is built around three foundational commitments: listening to patients, families, carers, staff and partners; leading through visible, accountable and compassionate leadership; and learning through a consistent, evidence-based system that turns insight into improvement and assurance.

# 2. Strengthening System-Wide Patient Safety in Hywel Dda UHB

The National Patient Safety Plan for NHS Wales 2026–2031<sup>1</sup> establishes patient safety as an essential priority for every part of NHS Wales and sets a clear expectation that organisations move beyond isolated initiatives towards a unified, system-wide approach rooted in listening, leadership, learning, prevention and continuous improvement. For Hywel Dda UHB, this means strengthening patient safety as a core organisational capability across acute, community, primary care, mental health, maternity, commissioned and partnership services, rather than treating safety as a separate programme or retrospective reporting process.

The national plan places the QMS at the centre of patient safety, bringing planning, improvement, control and assurance together in one consistent model. Planning will define safety priorities, standards, resources and trajectories; improvement will support co-designed interventions to reduce avoidable harm; control will strengthen daily operational grip, escalation and reliability; and assurance will provide evidence that risks are understood, acted on and improving. The QMS will therefore connect intelligence from patients, families, staff, incidents, concerns, claims, audit, outcomes and operational pressures into a single learning and improvement cycle.

Using the QMS will provide a clearer line of sight from frontline teams to Clinical Care Groups, executive forums, the Quality, Safety and Experience Committee (QSEC) and the Board. This will support earlier identification of emerging risks, reduced unwarranted variation, focused improvement effort and clearer evidence of compliance and impact.

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<sup>1</sup> [performanceandimprovement.nhs.wales/functions/quality-safety-and-improvement/quality-and-safety/national-patient-safety-plan-for-nhs-wales-2026-2031/national-patient-safety-plan-for-nhs-wales-2026-2031/?ts=1784041586428](https://performanceandimprovement.nhs.wales/functions/quality-safety-and-improvement/quality-and-safety/national-patient-safety-plan-for-nhs-wales-2026-2031/national-patient-safety-plan-for-nhs-wales-2026-2031/?ts=1784041586428)



Fig 1: National Patient Safety Plan for NHS Wales 2026-2031

### 3. Strategic alignment

The Plan directly supports the Health Board's strategic objective of Great Care and Planning Goal 6, 'Safe, Timely and High-Quality Care'. Patient safety is not a separate subset of this objective; it is the outcome of delivering safe, timely, equitable and high-quality care across every pathway. The national priorities establish the common NHS Wales focus, while the additional local priorities respond to Hywel Dda UHB's specific intelligence on access, service fragility, culture, workforce and resource sustainability.

The Health Board will align local delivery to the national plan's six enablers: leadership, workforce, culture, information and insights, learning, improvement and research, and whole-system working. These enablers will be embedded through the Health Board's QMS and reflected in organisational, Clinical Care Group and service-level quality and safety plans.

- Planning for patient safety: setting clear local goals, priorities, standards, responsibilities and improvement trajectories.
- Improvement for patient safety: using quality improvement methods, co-production and evidence-based interventions to reduce harm.
- Control of patient safety: strengthening daily operational management, escalation, reliability of standards and response to emerging risks.
- Assurance of patient safety: providing clear evidence to care groups, executive forums, quality committees and Board that risks are understood, controlled and improving.

### 4. Responding to current escalation and assurance expectations

This Patient Safety Plan supports the Health Board's improvement and assurance response by strengthening quality governance, improving organisational grip and creating a more integrated understanding of the principal quality and safety risks facing the organisation.

The Plan will support a consolidated Quality and Safety Position Statement that brings together strategic risks, operational quality indicators, access-to-care risks, patient outcomes, regulatory

requirements, improvement actions and evidence of impact. It will complement, rather than duplicate, the Board Assurance Framework (BAF), Corporate Risk Register and performance reports, and will consider complaints, National Reportable Incidents (NRIs) and healthcare-associated infections alongside the wider quality and safety risk profile.

Access-to-care risks will be recognised as patient safety risks where delays, service fragility, pathway pressures or poor timeliness increase the likelihood of avoidable harm. This includes risks associated with urgent and emergency care, cancer, planned care, diagnostics, delayed pathways of care and other services where access and outcomes are closely connected.

This integrated narrative will support clearer prioritisation, more consistent escalation and stronger evidence that improvement actions are reducing risk and improving outcomes. It will also provide a consistent basis for engagement with NHS Wales Performance and Improvement, regulators, partners and internal governance forums.

## 5. Local patient safety priorities

Hywel Dda UHB will adopt the seven national clinical safety priorities as the foundation of its local Patient Safety Plan and deliver them through existing organisational programmes wherever possible. The three additional local priorities are clearly identified as access, patient safety culture, and workforce and resource sustainability. They do not constitute a parallel plan; they identify the conditions and risks that may affect successful delivery in Hywel Dda UHB, informed by local incident themes, concerns, claims, patient experience, staff feedback, audit, regulatory findings, clinical outcomes and operational risk intelligence.

| National priority                                     | Hywel Dda UHB local response                                                                                                                                                                                                                                                  | Early focus                                                                                                                                                                                                                      |
|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Acute physical deterioration, including sepsis</b> | Strengthen recognition, escalation and response across acute, community and primary care pathways through a formal deterioration and sepsis programme, with dedicated project leadership, governance infrastructure and clear alignment with the resuscitation training team. | National Early Warning Score 2 (NEWS2) reliability, sepsis screening, clinical escalation, Call for Concern, deterioration learning reviews, project plan, infrastructure and named Clinical Care Group (CCG) and service leads. |
| <b>Deconditioning and frailty in the community</b>    | Reduce avoidable harm from falls, functional decline and delayed recovery through prevention, early intervention and integrated community care.                                                                                                                               | Frailty pathways, falls prevention, discharge-to-recover, community rehabilitation, care home safety intelligence.                                                                                                               |
| <b>Health care associated infections</b>              | Improve infection prevention and control reliability, surveillance, antimicrobial stewardship and outbreak learning.                                                                                                                                                          | Healthcare-associated infection (HCAI) reduction plans, infection prevention and control (IPC) audits, clinical environmental credentialling, environmental standards, antimicrobial improvement and outbreak governance.        |
| <b>Secondary care mental health safety</b>            | Strengthen safety measurement, therapeutic environments, ligature risk management and learning across inpatient and community mental health services.                                                                                                                         | Safety metrics, restrictive practice reduction, observation standards, incidents and concerns learning.                                                                                                                          |

|                                                              |                                                                                                                                                |                                                                                                                    |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| <b>People with a learning disability and neurodivergence</b> | Improve equitable access, reasonable adjustments, communication, safeguarding and learning from experience.                                    | Reasonable adjustment compliance, annual health checks, diagnostic overshadowing prevention, family feedback.      |
| <b>Maternity and neonatal services</b>                       | Respond to national assurance findings through strengthened governance, pathway reliability, workforce escalation and family-centred learning. | Triage, induction, neonatal escalation, postnatal support, maternity and neonatal safety intelligence.             |
| <b>Medicines safety</b>                                      | Develop a local medicines safety improvement programme aligned to the emerging national priority.                                              | High-risk medicines, prescribing and monitoring, transitions of care, medication incidents and pharmacy assurance. |

In addition to the national clinical safety priorities, Hywel Dda UHB will maintain local priorities where intelligence shows a significant relationship with avoidable harm, experience, outcome variation, resilience or assurance. A maintained position statement will explain how these priorities were identified, their alignment with national expectations and NHS Wales Performance and Improvement discussions, and how access, fragility, workforce and financial considerations inform prioritisation, escalation and assurance. Priorities will be tested through triangulation of quality, operational, workforce and financial intelligence, including evidence gaps, conflicting signals, likely trajectory and executive confidence.

| <b>Additional local priority</b>      | <b>Patient safety rationale</b>                                                                                                                                                                            | <b>Early focus</b>                                                                                                                                                                                             |
|---------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Access                                | Recognise delays, pathway pressures and service fragility as patient safety risks where they increase the likelihood of avoidable harm, deterioration, inequity or poor experience.                        | Urgent and emergency care, cancer, planned care, diagnostics, delayed pathways of care, harm reviews and triangulation with operational risk intelligence.                                                     |
| Patient safety culture                | Strengthen a just, restorative and learning culture so that patients, families, carers and staff feel able to raise concerns, speak up, share learning and contribute to safer care.                       | Speaking Up Safely, Working in Confidence, Duty of Candour, Call for Concern, Listening to People, safety culture intelligence and shared learning from harm and excellence.                                   |
| Workforce and resource sustainability | Understand and manage the relationship between workforce capacity, skill mix, wellbeing, financial resource, estates, equipment and digital constraints and the ability to deliver consistently safe care. | Workforce risk intelligence, safe staffing, skill mix, staff wellbeing, temporary staffing, service resilience, financial resource, capacity planning, equipment availability and resource-related escalation. |

## 6. Delivery framework

Delivery will be coordinated through the six national enabling functions: leadership, workforce, culture, information and insights, learning, improvement and research, and whole-system working. These are not separate workstreams requiring additional governance; they are cross-cutting capabilities that support delivery of the seven national and three additional local priorities through existing programmes, groups and accountability arrangements. Patient safety objectives, measures and accountabilities will be incorporated into relevant programmes, including urgent and emergency care, hospital fragility, planned care transformation and other established service improvement arrangements. Overall accountability for the Plan rests with

the Executive Director of Nursing, Quality and Patient Experience. Each priority will have a Senior Responsible Owner, with additional executive sponsorship agreed where required, and Clinical Care Groups and executive functions accountable for delivery within their respective areas. Existing evidence and reporting will be reused wherever possible to avoid duplication or additional reporting burden. Delivery will be phased to establish foundations in 2026–2027, deliver enhancements between 2027 and 2031, and embed sustainability beyond 2031.

| Health and Care Quality Standards Enabler | Local objective                                                     | What this means for Hywel Dda UHB                                                                                                                                                                                                                                                                     | QMS link                         | Expected impact                                                                                                                      |
|-------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| Leadership                                | Visible, connected and accountable leadership for patient safety.   | Clear executive ownership, Clinical Care Group accountability, named senior responsible owners, CCG/service leads for cross-cutting priorities, consistent escalation routes and Board-level oversight of patient safety priorities.                                                                  | Planning and assurance.          | Stronger accountability, clearer prioritisation, earlier escalation and greater confidence that risks are being actively managed.    |
| Workforce                                 | Staff have the skills, confidence and support to deliver safe care. | Local implementation of the national patient safety curriculum, role-based safety capability and support for clinical and non-clinical teams to recognise, respond to and reduce risk.                                                                                                                | Planning and improvement.        | More consistent safety behaviours, reduced variation and improved staff confidence in managing patient safety risks.                 |
| Culture                                   | A just, restorative and learning safety culture.                    | Working in Confidence, Speaking Up Safely, Duty of Candour, Call for Concern and Listening to People are embedded as core mechanisms for openness, learning and improvement.                                                                                                                          | Control, learning and assurance. | Patients, families and staff feel able to raise concerns, and learning is acted on visibly and consistently.                         |
| Information and insights                  | A single view of patient safety intelligence.                       | Scheduled multidisciplinary triangulation of incidents, concerns, claims, mortality, audit, outcomes, workforce intelligence, financial intelligence, patient experience and operational risk to identify emerging themes and priorities, rather than relying only on review after harm has occurred. | Control and assurance.           | Earlier identification of emerging risks, stronger surveillance and better targeted intervention where the risk of harm is greatest. |
| Learning, improvement and research        | Learning drives measurable improvement.                             | Patient safety learning forums, improvement programmes, shared learning, audit, evaluation and research are used to reduce repeat harm and evidence the impact of change.                                                                                                                             | Improvement and assurance.       | Reduced repeat incidents, stronger evidence of improvement and better spread of successful interventions across services.            |
| Whole-system approach                     | Patient safety is connected across pathways,                        | Acute, community, primary care, mental health, maternity, commissioned services and partnership services are aligned around shared safety priorities,                                                                                                                                                 | Planning, control and assurance. | Reduced fragmentation, improved pathway safety and stronger whole-system                                                             |

services and  
partners.

escalation routes and learning  
systems.

management of harm  
and risk.

## 7. Hywel Dda implementation plan

Each of the seven national and three additional local priorities will be mapped to the six enabling functions through a single delivery matrix. The matrix will identify the Senior Responsible Owner, any required executive sponsor, the accountable Clinical Care Groups and executive functions, the existing programme or service route through which delivery will occur, the contribution required from each enabling function, milestones, measures, dependencies, risks and the evidence required to demonstrate impact. Workstream leadership and executive sponsorship will be confirmed following further Executive Team consideration. This approach will provide a clear line of sight from priority to action, accountability, assurance and outcome without creating parallel governance or additional reporting.

This implementation plan translates the national patient safety actions into local delivery through the integrated QMS cycle of planning, improvement, control and assurance.

### 7.1 Leadership

| Local action                                                                                                                                                                                                                                                                                                                  | QMS link                         | Lead route                                                                  | Timeline           | Expected impact                                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-----------------------------------------------------------------------------|--------------------|------------------------------------------------------------------------------------|
| <b>Confirm executive sponsorship, named senior responsible owners and CCG and service leads for each patient safety priority, including cross-cutting national priorities such as acute deterioration and sepsis, deconditioning and frailty, learning disability and neurodivergence, and maternity and neonatal safety.</b> | Planning and assurance           | Executive Team and Quality, Safety and Experience Committee                 | Phase 1: 2026–2027 | Clear accountability, improved prioritisation and stronger Board oversight.        |
| <b>Define patient safety responsibilities for Clinical Care Groups, service groups and corporate functions.</b>                                                                                                                                                                                                               | Planning and control             | Clinical Care Group governance and executive quality routes                 | Phase 1: 2026–2027 | Consistent ownership of safety risks, actions and improvement trajectories.        |
| <b>Strengthen escalation routes for emerging risks, deteriorating safety indicators and unresolved actions.</b>                                                                                                                                                                                                               | Control and assurance            | Quality surveillance, risk management and executive escalation arrangements | Phase 1: 2026–2027 | Earlier recognition of harm, clearer escalation and faster intervention.           |
| <b>Embed visible leadership for patient safety through executive WalkRounds, safety conversations and frontline learning.</b>                                                                                                                                                                                                 | Planning, learning and assurance | Executive leadership and Clinical Care Group leadership teams               | Phase 1: 2026–2027 | Improved trust, stronger safety culture and better understanding of everyday work. |

### 7.2 Workforce

| Local action                                                                                            | QMS link | Lead route                               | Timeline           | Expected impact                        |
|---------------------------------------------------------------------------------------------------------|----------|------------------------------------------|--------------------|----------------------------------------|
| Map local patient safety, innovation and service improvement training requirements against the national | Planning | Patient safety, workforce, education and | Phase 2: 2027–2028 | Clear understanding of capability gaps |

|                                                                                                                                                                                                  |                                 |                                                                                      |                    |                                                                                                |
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| Patient Safety Curriculum, ensuring staff can use learning from incidents, excellence and everyday work to improve care rather than reinforce blame.                                             |                                 | professional leadership routes                                                       |                    | and priority learning needs.                                                                   |
| <b>Develop role-based patient safety learning for clinical and non-clinical staff, including incident learning, Duty of Candour, safeguarding, IPC, medicines safety and improvement skills.</b> | Planning and improvement        | Workforce and organisational development, clinical education and professional forums | Phase 2: 2027–2031 | Improved confidence, consistency and safety behaviours across teams.                           |
| <b>Build patient safety capability within Clinical Care Groups through improvement coaching, safety huddles, learning reviews and local safety dashboards.</b>                                   | Improvement and control         | Clinical Care Group quality governance and improvement teams                         | Phase 2: 2027–2031 | Greater local ownership of safety improvement and reduced variation in practice.               |
| <b>Use workforce intelligence, staff experience and operational pressures to inform patient safety risk assessment and improvement planning.</b>                                                 | Planning, control and assurance | Workforce governance, quality surveillance and executive quality routes              | Phase 2: 2027–2031 | Better understanding of the relationship between workforce conditions and patient safety risk. |

### 7.3 Culture

| Local action                                                                                                                                                    | QMS link                        | Lead route                                                                       | Timeline             | Expected impact                                                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|----------------------------------------------------------------------------------|----------------------|--------------------------------------------------------------------------------------------------|
| <b>Embed just, restorative and learning culture principles into incident review, concerns management, complaints, safeguarding and staff support processes.</b> | Control, learning and assurance | Patient safety, concerns, safeguarding, workforce and clinical governance routes | Phase 1–2: 2026–2031 | More open learning, improved staff experience and reduced blame-based responses.                 |
| <b>Strengthen implementation of Speak Up Safely, Working in Confidence, Duty of Candour, Call for Concern and Listening to People.</b>                          | Control and assurance           | Executive quality routes, concerns governance and patient experience routes      | Phase 1: 2026–2027   | Patients, families and staff have clearer routes to raise concerns and receive timely responses. |
| <b>Use safety culture intelligence from staff feedback, speaking-up themes, incidents, concerns and patient stories to identify areas requiring support.</b>    | Control, learning and assurance | Quality surveillance, workforce intelligence and Clinical Care Group governance  | Phase 2: 2027–2031   | Better targeting of cultural improvement and stronger evidence of psychological safety.          |
| <b>Share learning from excellence, improvement and everyday work as well as from harm events.</b>                                                               | Learning and improvement        | Patient safety learning forums and Clinical Care Group improvement routes        | Phase 2: 2027–2031   | Balanced Safety I and Safety II learning that builds resilience and spreads good practice.       |

### 7.4 Information and insights

| Local action                                                                                                                                                                                             | QMS link              | Lead route                                                          | Timeline           | Expected impact                                                                                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|---------------------------------------------------------------------|--------------------|------------------------------------------------------------------------------------------------------------------------------------|
| <b>Develop a single patient safety intelligence model that triangulates incidents, concerns, claims, mortality, audit, patient experience, workforce indicators, financial intelligence, operational</b> | Control and assurance | Quality surveillance, information, patient safety and Clinical Care | Phase 1: 2026–2027 | Earlier identification of emerging and principal quality and safety risks, more reliable prioritisation of improvement effort, and |

|                                                                                                                                                                                                |                                    |                                                                                                  |                      |                                                                                                               |
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| <b>risk, access-to-care risks, regulatory intelligence and Board Assurance Framework risks,</b> including explicit review of alignment, contradiction, evidence gaps and executive confidence. |                                    | Group governance routes                                                                          |                      | stronger evidence that actions are reducing risk and improving outcomes.                                      |
| <b>Align local patient safety measures to the Quality Outcomes Framework and Health and Care Quality Standards.</b>                                                                            | Planning and assurance             | QMS dashboard development and executive quality reporting                                        | Phase 1–2: 2026–2031 | Clearer evidence of impact and better alignment with national reporting expectations.                         |
| <b>Agree escalation triggers for deteriorating safety signals, repeated themes and areas of unwarranted variation.</b>                                                                         | Control and assurance              | Quality surveillance, risk management and executive escalation arrangements                      | Phase 1: 2026–2027   | More proactive response to risk before harm becomes sustained or widespread.                                  |
| Schedule routine multidisciplinary patient safety control reviews to triangulate data, audit, outcomes, experience, workforce, finance and operational risk before issues escalate.            | Control and assurance              | Clinical Care Group quality governance, quality surveillance, audit and executive quality routes | Phase 1: 2026–2027   | More proactive control of patient safety risks and reduced reliance on reactive review following harm events. |
| <b>Develop service and care group dashboards that support daily management, local improvement and Board-level assurance.</b>                                                                   | Control, improvement and assurance | Clinical Care Group quality governance and QMS reporting routes                                  | Phase 2: 2027–2031   | Improved visibility of safety performance from frontline teams to Board.                                      |

## 7.5 Learning, improvement and research

| Local action                                                                                                                                                                                                                                                     | QMS link                            | Lead route                                                                                                                                                 | Timeline             | Expected impact                                                                        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|----------------------------------------------------------------------------------------|
| <b>Establish a patient safety learning system,</b> including CCG-based lessons learned and improvement forums, <b>that connects learning from incidents, concerns, claims, mortality, audits, inspections, patient experience, good practice and innovation.</b> | Learning, improvement and assurance | Patient safety learning forums, Clinical Care Groups and executive quality routes                                                                          | Phase 1: 2026–2027   | Reduced repeat harm and stronger organisational memory from safety learning.           |
| <b>Align local improvement programmes to the national clinical safety priorities and locally identified risk themes.</b>                                                                                                                                         | Planning and improvement            | Improvement governance, Clinical Care Group delivery plans and Quality, and Safety Intelligent Group (QSIG) routes                                         | Phase 1–2: 2026–2031 | Improvement effort focused on the greatest risk of avoidable harm.                     |
| <b>Use structured improvement methodology, co-production and measurement for priority safety programmes.</b>                                                                                                                                                     | Improvement and assurance           | Quality improvement teams, patient experience routes, innovation and service improvement training, CCG lessons learned forums and service-level governance | Phase 2: 2027–2031   | More reliable delivery of change and stronger evidence that interventions are working. |

|                                                                                                                                                                                                                                                                      |                                     |                                                                                                                                                          |                    |                                                                                                                                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Develop evaluation, innovation and research partnerships, including multi-professional research leadership and development routes for advanced and consultant clinical practice, to understand emerging patient safety risks and the impact of interventions.</b> | Learning, improvement and assurance | Research, innovation, improvement, multi-professional research leadership, professional development and advanced and consultant clinical practice routes | Phase 2: 2027–2031 | Improved evidence, stronger spread of learning, clearer multi-professional research capability, support for research funding and better long-term sustainability. |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|

## 7.6 Whole-system approach

| Local action                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | QMS link                            | Lead route                                                                    | Timeline                           | Expected impact                                                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------------------------------------------------|------------------------------------|---------------------------------------------------------------------------------------------------|
| <b>Hywel Dda UHB will adopt the national clinical safety priorities and connect them across acute, community, primary care, mental health, maternity, commissioned and partnership pathways. Delivery will place particular emphasis on prevention, early identification and timely intervention where missed opportunities may result in avoidable deterioration or poorer outcomes. This includes identifying pathway risks before presentation at an emergency department, supporting access to the right care, at the right time and in the right place, and using intelligence across organisational boundaries to reduce fragmentation and improve pathway safety.</b> | Planning, control and assurance     | Clinical Care Groups, primary care, partnership and executive quality routes  | Phase 1–2: 2026–2031               | Reduced fragmentation and stronger management of pathway-level risk.                              |
| <b>Strengthen safety assurance for independent contractor and commissioned services through proportionate intelligence, escalation and learning routes.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Planning and assurance              | Primary care, commissioning, contract assurance and quality governance routes | Phase 2: 2027–2031                 | Improved whole-system visibility of safety risks beyond directly provided services.               |
| <b>Work with partners, including local authorities, Llais, regulators, regional networks and national programmes, to share intelligence and coordinate safety improvement.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Planning, learning and assurance    | Partnership governance, regional networks and executive quality routes        | Phase 1–2: 2026–2031               | Better alignment of action across organisational boundaries and improved use of lived experience. |
| <b>Review the implementation plan annually and refresh priorities at least every two years in line with national review points and emerging local intelligence.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Planning, improvement and assurance | Executive Team, QSEC and Board                                                | Annual review and two-year refresh | Sustained relevance, continuous learning and stronger alignment to national and local priorities. |

## 8. Measuring impact

Impact will be measured through a balanced set of outcome, process, experience, culture and assurance measures. National Quality Outcomes Framework measures will be used where available, supported by local measures and improvement trajectories. Reporting will show whether principal safety risks are improving, stable, deteriorating or uncertain, taking account of current controls, evidence gaps, confidence in the available intelligence and the likely direction of travel over the next three to six months. Measures will be reviewed annually and refreshed at two-year intervals to reflect national review points and emerging risks.

For each priority, reporting will include the accountable executive sponsor and senior responsible owner; agreed outcome, process, experience, culture and assurance measures; baseline and trajectory; delivery milestones; current risk and control position; dependencies; evidence of impact; and an overall assessment of whether delivery is on track, at risk or off track. Reports will distinguish activity from impact and identify decisions or escalation required from QSIG, the Formal Executive Team (FET) or QSEC.

If the Plan is successful, the Health Board will identify risks earlier, intervene before avoidable harm occurs, reduce unwarranted variation and repeat harm, and provide more timely, reliable and equitable care across pathways. Patients, families and staff will experience clearer routes to raise concerns and will see evidence that learning leads to change. Leaders will have an integrated view of safety, access, workforce and resource intelligence, with transparent ownership and stronger assurance that actions are improving outcomes.

A clinical environmental credentialing approach will be developed to describe what good looks like in clinical areas, supporting services to assess environmental safety, infection prevention standards, equipment readiness, patient flow, privacy, dignity and physical conditions as part of routine assurance and improvement.

- Outcome measures: avoidable harm, mortality indicators, HCAI rates, falls with harm, pressure damage, maternity and neonatal outcomes, medicines harm and mental health safety outcomes.
- Process measures: compliance with escalation standards, sepsis screening, IPC audit actions, medicines monitoring, Call for Concern implementation and safety huddle reliability.
- Experience measures: concerns themes, compliments, patient stories, Llais intelligence, patient-reported experience measures (PREMs), family feedback and staff speaking-up themes.
- Culture measures: staff survey safety culture indicators, civility and psychological safety measures, Duty of Candour compliance and just culture learning.
- Assurance measures: timeliness and quality of incident reviews, closure and impact of actions, audit compliance, regulatory findings, claims themes, access-to-care risk reporting, Board Assurance Framework alignment and triangulated evidence of improvement.

## 9. Governance and accountability

Overall executive accountability for the Patient Safety Plan rests with the Executive Director of Nursing, Quality and Patient Experience, supported by the Executive Medical Director, the Executive Director of Allied Health and Health Science and other executive leads whose portfolios contribute to individual priorities. Each priority and enabling workstream will have a named executive sponsor and senior responsible owner, with Clinical Care Groups and executive functions within their respective areas. Additional executive sponsorship will be agreed where a priority requires cross-portfolio leadership. The six enablers are enabling functions rather than separate delivery workstreams and will operate through existing governance, performance and improvement arrangements. Individual lead and supporting executive roles shown below are indicative and will be confirmed following further Executive Team consideration.

| <b>Indicative executive contribution by patient safety enabling function – subject to confirmation</b> |                                                                |                                                                                                                                                                    |
|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Area</b>                                                                                            | <b>Indicative lead executive role</b>                          | <b>Supporting executive roles</b>                                                                                                                                  |
| <b>Leadership</b>                                                                                      | Chief Executive                                                | Executive Director of Nursing, Quality and Patient Experience                                                                                                      |
| <b>Workforce</b>                                                                                       | Executive Director of Workforce and Organisational Development | Executive Director of Nursing, Quality and Patient Experience; Executive Medical Director; Executive Director of Allied Health and Health Science                  |
| <b>Culture</b>                                                                                         | Chief Executive                                                | Executive Director of Workforce and Organisational Development; Executive Director of Nursing, Quality and Patient Experience                                      |
| <b>Information and insights</b>                                                                        | Executive Director of Nursing, Quality and Patient Experience  | Director of Finance; Chief Operating Officer; Executive Medical Director; Executive Director of Allied Health and Health Science                                   |
| <b>Learning, improvement and research</b>                                                              | Executive Medical Director                                     | Executive Director of Nursing, Quality and Patient Experience; Executive Director of Allied Health and Health Science                                              |
| <b>Whole-system approach</b>                                                                           | Chief Operating Officer                                        | Chief Executive; Executive Director of Nursing, Quality and Patient Experience; Executive Medical Director; Executive Director of Allied Health and Health Science |

Delivery will be supported through patient safety, quality governance, safeguarding, infection prevention, clinical leadership, operational management and improvement functions. Clinical Care Groups and service groups will implement relevant actions, maintain oversight of local risks, escalate concerns promptly and demonstrate measurable impact through routine assurance arrangements.

The Plan will be governed through the QMS so that patient safety is embedded within strategic planning, operational control, improvement and assurance. The revised Plan will be presented to the Quality and Safety Intelligence Group (QSIG) in October 2026. QSIG will act as custodian of integrated patient safety intelligence, using its existing remit and information flows to triangulate patient safety data, review delivery confidence, identify emerging risks and exceptions, and agree how the priorities should be addressed through its meetings. The supporting position statement will be maintained as a live, forward-looking view that is reviewed in real time rather than as a retrospective account of performance or incidents. Existing evidence, governance minutes, dashboards and reports will be reused wherever possible so that implementation does not create duplicate work or additional reporting. A patient safety progress report will be presented to the Formal Executive Team (FET) at an agreed frequency, with exception escalation between reporting cycles where required, and onward assurance reporting to the Quality, Safety and Experience Committee (QSEC). Reporting will provide a clear line of sight from ward, team and service intelligence through Clinical Care Group governance to executive and Board-level scrutiny.

Governance arrangements will align strategic risks, operational quality indicators, access-to-care risks, patient outcomes, regulatory requirements, improvement actions and evidence of impact to support a consolidated Quality and Safety position for the Board and external stakeholders.

Reports will distinguish fact, interpretation and judgement; identify where assurance is strong or incomplete; and highlight risks that may be becoming normalised or require further action or escalation.

A coordinated communication and engagement campaign will bring the Plan to life for all staff groups and partners. Communications will explain what patient safety means in different roles, how the national and local priorities connect to everyday work, what staff and teams will be expected to do differently, and how progress and learning will be shared. The approach will use accessible ward-to-board messaging, staff stories, patient and family experience, executive and Clinical Care Group leadership channels, team conversations and regular feedback on improvements achieved.

## **10. Conclusion**

Hywel Dda UHB's Patient Safety Plan provides a clear local response to the National Patient Safety Plan for NHS Wales 2026–2031. It sets out how the Health Board will strengthen patient safety as a core organisational capability, using the Quality Management System to connect strategic planning, operational control, improvement activity and assurance reporting into one coherent approach.

By aligning national priorities with local risks, patient and staff experience, safety intelligence and Clinical Care Group delivery, the plan creates a stronger line of sight from frontline practice to Board-level assurance. Its success will depend on visible leadership, a just and learning culture, reliable data, whole-system collaboration and sustained improvement capability across all services and partners.

The intended outcome is a Health Board where avoidable harm is reduced, risks are identified earlier, learning is acted on consistently, and patients, families, carers and staff can see that their voices are shaping safer care. This plan should therefore be used as both a strategic framework and a practical delivery mechanism for embedding patient safety into everyday work across Hywel Dda UHB.