

National Patient Safety Plan for NHS Wales

2026-2031



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Cabinet Secretary Foreword

I am pleased to introduce the National Patient Safety Plan for NHS Wales, which sets out a clear and unified commitment to strengthen the safety and quality of care. It is a plan developed by the NHS, for the NHS, shaped by collaboration across the healthcare service and grounded in the experience, expertise and insight of those delivering and receiving care every day.

Patient safety is at the heart of trust in our health and care services. Staff provide care with the utmost of compassion and professionalism, but in a demanding and often complex system, there is always a risk that avoidable harm might happen.

This plan is designed to respond to that risk with honesty, ambition and a shared determination to drive improvement. It places a strong emphasis on listening to patients, families and staff, acknowledging that safe care is shaped not only by individual actions but by the systems, cultures and conditions in which people work.

For the first time, Wales has a coherent all nation framework which moves us beyond isolated initiatives and towards a consistent, system wide approach rooted in learning, prevention and continuous improvement. It aligns with the statutory duties in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and supports wider strategic ambitions.

By embedding patient safety in a strengthened national quality management system, it brings leadership, improvement, assurance and control together in a single structure.

At the core of this plan is a non-negotiable commitment to a safety culture, visible and engaged leadership, psychologically safe working environments, and meaningful learning from experience. It recognises the insight and expertise of healthcare professionals should be routinely used – and not an aspiration. It places a strong emphasis on listening to patients, families and staff.

Delivering this plan will also be a collective endeavour. Through sustained partnership, openness and a shared commitment to learning, we can reduce avoidable harm, strengthen safety culture and build a more resilient NHS Wales, which continues to earn the confidence of the public and supports its workforce to provide high quality, compassionate care every day.

Jeremy Miles MS
Cabinet Secretary for Health and Social Care



Executive Summary

The National Patient Safety Plan sets out a bold aim: to make care in Wales safer by reducing avoidable harm and building a culture where learning and improvement are at the heart of everything we do.

Patient safety is the foundation of high-quality healthcare. Yet today, safety efforts across Wales are often fragmented and focused on compliance rather than continuous improvement. This Plan changes that. Aligned with A Healthier Wales and the Health and Social Care (Quality and Engagement) (Wales) Act 2020, it creates a unified, system-wide framework that makes patient safety an essential priority for every part of NHS Wales.

This is a whole system Patient Safety Plan encompassing primary, community, secondary and social care. The quality and safety of services delivered by independent contractor professions—including General Medical Services—remain the responsibility of Health Boards, and the Plan supports consistent, proportionate assurance across all parts of the system.

At the centre of the Plan is a Quality Management System (QMS) approach, bringing together planning, improvement, control and assurance into a single, consistent model for patient safety. This approach is guided by three foundational pillars that are supported by six key enablers—leadership, workforce, culture, information and insights, learning and research and a whole-systems approach— and collectively drive the delivery of safe, high-quality care across NHS Wales.

Crucially, this approach recognises that safety is not the same as performance: performance data tells us what has already happened, whereas safety is concerned with anticipating what could happen next. By elevating safety intelligence through the QMS and the Quality Outcomes Framework (QOF), the Plan strengthens NHS Wales' ability to detect risks early, learn proactively, and prevent avoidable harm.

NHS Wales Performance and Improvement will lead delivery, in partnership with national organisations and local systems, ensuring health boards and trusts have the support, expertise and frameworks they need to succeed.

The Plan is bold in ambition but practical in design: to reduce avoidable harm, strengthen safety culture and embed learning at every level of NHS Wales.



1. Setting the Scene

Patient safety is the foundation of high-quality care. Yet in Wales, despite notable progress under the Duty of Quality, there is currently no single national plan dedicated to patient safety. As a result, activity in this area remains disjointed, often reactive and too focused on compliance rather than on learning and improvement. This fragmentation leaves both patients and staff vulnerable to the recurrence of avoidable harm, and it prevents the development of the system-level resilience needed to meet the growing pressures on the NHS in Wales.

Recent scrutiny reinforces the urgency. Healthcare Inspectorate Wales' Annual Report 2024-25 describes a system "under sustained pressure"¹, where dedicated staff deliver good care in difficult conditions but risks to patient safety persist and improvement is not consistently sustained.

Systems tend to revert to familiar, reassurance-seeking behaviours: counting incidents rather than understanding risk, closing actions rather than deepening insight and narrowing focus just when it needs most to widen. Harm often emerges not from a single dramatic failure but from the everyday conditions of work – trade-offs, assumptions and variability in processes – that interact in ways that are hard to see in the moment².

¹ Healthcare Inspectorate Wales (2025) **Annual Report 2024-2025**

² Baker, T. (2026) **Why I worry the NHS could slip backwards on patient safety**. Health Services Safety Investigations Body

Historically, national safety activity has been dominated by data and systems most visible within secondary care. This has created a risk that the safety conditions, pressures and intelligence from primary and community care—particularly General Medical Services—are not consistently surfaced or weighted in national understanding.

Our response must therefore shift from a singular secondary care focus and incident closure to systems learning, connecting signals from incidents, experience and operations to proactive redesign at scale – a necessary change voiced through the new Listening to People approach for NHS Wales³. The national QMS set out in this Plan is designed to do exactly that – linking planning, improvement, control and assurance into one learning system for Wales.

Health inequalities continue to compound these challenges. They are estimated to cost acute NHS services in Wales approximately £322 million per year⁴ through avoidable hospital admissions, delayed treatments and chronic conditions worsened by socioeconomic factors. The prevalence of chronic diseases such as diabetes, cancer and dementia is projected to rise further in the coming years.

In NHS Wales, quality and patient safety are not separate ambitions—they are fundamentally interconnected and mutually reinforcing. High-quality care cannot exist without safety and safe care must be grounded in evidence-based, person-centred practices that define quality. This National Patient Safety Plan shares a unified aim to support and enable the existing strategic Duty of Quality guidance: to deliver care that is consistently safe, effective and responsive to the needs of the people of Wales.

Safety is recognised as a core domain of healthcare quality, as defined by the Institute of Medicine and adopted internationally⁵. It is also one of the six Domains of Quality in the Duty of Quality:

Safe: Our healthcare system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again. People’s health, safety and welfare are actively promoted and protected; risks are identified and monitored and where possible, risks to safety are reduced or prevented. We promote and protect the wellbeing and safety of children and adults who become vulnerable or at risk at any time. Where children or adults may be experiencing or are at risk of abuse or neglect, we take appropriate, timely action and report concerns.⁶

3 Senedd Cymru (2025) **National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2025**

4 WHO Collaborating Centre on Investment for Health and Well-being, Public Health Wales (2021) **Cost of health inequality to the NHS in Wales**

5 Institute of Medicine (2001) *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, D.C: National Academy Press; 2001.

6 Welsh Government (2023) **The Duty of Quality Statutory Guidance 2023 and Health and Care Quality Standards 2023**.

Preventing harm, reducing unwarranted variation and improving outcomes are all shared goals that require a coordinated and system-wide approach. The launch of the national Quality Outcomes Framework (QOF) in NHS Wales in October 2025 has been a step forward to achieving these goals. It provides a powerful tool for measuring the system-level improvements in care which will be enabled by the National Patient Safety Plan.

NHS Wales Performance and Improvement will deliver a range of actions that are captured in the Plan to strengthen the NHS Wales safety culture of learning, transparency and collaboration. It will guide health boards and trusts in aligning strategic priorities, measuring progress and fostering environments where patients and staff alike feel protected, respected and empowered. The Plan will also enhance connections between patient and public insight—through Llais—and health bodies, ensuring lived experience informs safety improvement at every level. In addition, regulators will continue to play a vital role in strengthening patient safety across the healthcare system through proportionate, risk-based inspection and oversight. Given current workforce pressures, rising demand and financial constraints, the Plan will be delivered in phases. This phased approach ensures that priority actions can be implemented swiftly while subsequent actions are co-designed and sequenced with staff, patients and partners. It is a pragmatic yet forward-looking Plan—one that addresses today's challenges while laying the foundation for a resilient, learning health system for tomorrow.

A broad spectrum of harm can occur when care is not safe—not only physical injury but also psychological, financial and social harm. Patients themselves are often best placed to define harm and articulate its impact. All forms of avoidable harm matter and this Plan is designed to underpin the creation of healthcare environments that are truly safe.

In 2023-24, Welsh health bodies received £114.6 million in reimbursements for claims and redress linked to unsafe or poor-quality care, with the highest numbers arising from maternity services, emergency departments and trauma & orthopaedics⁷. This financial burden provides a powerful imperative for system-wide improvement and cultural change—ensuring that healthcare delivery across Wales continues to become safer and more effective. It reflects not only the financial cost of avoidable harm but also the strain placed on NHS Wales' resources — resources that could otherwise be invested in frontline services, staffing, equipment, or innovation.

⁷ NHS Wales Shared Services (2025) Welsh Risk Pool and Legal & Risk Services Annual Review 2024–2025

2. Aim of the National Patient Safety Plan

A National Patient Safety Plan is a critical step in strengthening our healthcare system. The aim is:

Listening, leading and learning for safer care in Wales.

This will be achieved through three foundational pillars which run consistently throughout and shape the direction of the Plan:

Listening

Listening goes beyond hearing — it amplifies the voices of patients, staff and partners to shape safer care and turn feedback into actionable insight. Embedding co-production ensures lived and learned experiences drive meaningful improvements. By focusing on prevention, tackling harm and inequalities early and creating transparent feedback loops, this approach builds trust, strengthens relationships and ensures the healthcare system reflects what matters most to the people it serves.

Leadership

Visible, accountable leadership makes patient safety a core strategic priority. Leaders create systems and cultures that foster transparency, learning and reliability, while empowering multi-disciplinary teams to identify risks, act quickly and prevent harm through continuous improvement.

Learning

Proactive, systematic use of real-time insights and data —coupled with collaborative reflection—to drive continuous redesign of healthcare systems, foster transparency and feedback and co-create improvements in safety. Incorporating a learning approach that not only detects errors and implements corrective actions but also embodies ongoing, collective and system-wide learning that embeds safety into everyday healthcare practice.

The National State of Patient Safety (2024) found that in 2023, 13,495 deaths could have been avoided if the UK matched the top 10% of OECD countries⁸. In 2022, this figure was 12,675 deaths. A collective focus on the three foundational pillars will create a unified, learning health system that relentlessly reduces avoidable harm, strengthens safety culture and delivers consistently safe, effective and equitable care for every person in Wales. This will contribute to a reduction in hospital mortality, evidenced through All Wales Risk Adjusted Mortality Index (RAMI) and Crude Mortality, an increase in the number of days of safe care delivered between never events and improve overall patient experience scores. Ensuring that the people of Wales are put first – today and tomorrow.

⁸ Illingworth J, Fernandez Crespo R, Hasegawa K, Leis M, Howitt P, Darzi A (2024) **The National State of Patient Safety 2024: Prioritising improvement efforts in a system under stress.** Imperial College London.



3. Why We Are Taking Action

The national strategic direction for NHS Wales is set out in **A Healthier Wales**⁹, the long-term strategy for integrated health and social care. In 2020, the **Health and Social Care (Quality and Engagement) (Wales) Act**¹⁰ introduced the **Duty of Quality and Duty of Candour**, which came into effect in April 2023. However, a gap remains between these statutory duties and the delivery of services as there is no national plan defining the safety actions to complement the duties.

This Plan is grounded in the Duty of Quality and the focus on quality for future generations captured in the **Well-being of Future Generations Act 2015**¹¹, elevating patient safety—a critical component of quality—as both a legal and operational priority. It also supports and aligns to Welsh Government’s **Clinical Governance Framework for NHS Wales (2026)** which describes the arrangements in place to assure that health services are safe, of consistently high quality, and aligned with national standards. The framework will support a common understanding of clinical governance across NHS Wales and provide a basis for reviewing NHS organisations and system arrangements against a national standard.

Equally, the multi professional **National Clinical Excellence Framework (NCEF)** complements both the Plan and the **Clinical Governance Framework** by offering a nationally consistent approach to evidencing excellence, supporting transparency, learning and improvement across NHS Wales.

NHS Wales must ultimately reduce population level harms through a long-term shift toward prevention. The Plan addresses where the highest risks, greatest pressures and most urgent opportunities to improve quality and patient safety currently sit. The actions target patient safety across the continuum of care - from prevention to end of life care – and across primary, community, secondary and social care to ensure coordinated action that collectively improve population patient safety. The Plan seeks to work alongside and complement NHS Wales’ **Community by Design** approach to redesign health and care services so that far more care is delivered closer to home, in community settings, so that together both initiatives collectively focus on the both immediate, acute patient safety priorities and longer-term population-level harm and transformation.

NHS Wales faces significant system challenges, including service pressures, investigation backlogs, recurring patient safety incidents and harm resulting from speciality and pathway delays – and ultimately a lack of patient flow. Evidence of system-wide learning is limited, and Wales has yet to define a national operating model or plan for safety.

9 Welsh Government (2021) **A Healthier Wales: our plan for health and social care**

10 Senedd Cymru (2020) **Health and Social Care (Quality and Engagement) (Wales) Act 2020**

11 Welsh Government (2015) **The Well-being of Future Generations Act**

As a result, responses are largely reactive, focused on compliance and investigation, with little emphasis on proactive learning. In primary care, safety risks often arise not from high volume incidents but from system conditions—such as access pressure, continuity of care, diagnostic uncertainty, medicines management and workforce resilience. These forms of harm do not readily surface in traditional incident datasets, yet they are central to preventing avoidable harm earlier in the pathway.

A lack of integrated digital infrastructure compounds these challenges, creating barriers to timely data sharing, proactive risk management and system-wide transparency. Digital connectivity is positioned as a core enabler providing real-time data and improved data integration to support proactive decision-making. This approach aligns with the vision set out in A Healthier Wales, ensuring that technology is leveraged to promote equity, enhance staff capability and strengthen resilience across the healthcare system.

Taken together, all of the above factors highlight a clear opportunity to establish a nationally aligned patient safety system that balances compliance with proactive improvement and fosters a culture of learning and resilience — an approach already beginning to emerge through the recent National Maternity and Neonatal Assurance Assessment.



4. Our National Clinical Safety Priorities

NHS Wales Performance and Improvement will provide national support to improve outcomes in strategic national clinical safety priorities identified by the healthcare system and Welsh Government using qualitative and quantitative data, as part of a whole system approach.

National clinical safety priorities are identified by triangulating proactive data driven analysis, reactive responses to incidents and qualitative insights from services as well as broader system signals from primary and community care, where risk manifests differently and may require population-level monitoring rather than incident-level analysis. The evidence base includes incident reporting and harm level data, surveillance information from the Once for Wales Concerns Management System (OfWCMS), and analysis of patient safety incidents, claims and redress in line with Putting Things Right.

The triangulation of sources identifies systemic patient safety risks and issues and encourages learning. National governance structures, with appropriate oversight, will determine and agree the priorities. Progress will be captured through the STEEEP measures in the Quality Outcomes Framework, existing PROMS and PREMS and ultimately in the Health Outcomes Framework for NHS Wales.

Focusing on a targeted number of patient safety priorities enables Wales to achieve meaningful, system-wide improvement despite limited resources. It concentrates leadership attention, funding and improvement effort on the areas of greatest harm, reducing fragmentation and initiative fatigue. Clear national priorities allow faster alignment across policy and practice, support better measurement and learning and make safety goals easier for the healthcare system and the public alike to understand. Early success in these areas builds capability, confidence and infrastructure, creating a strong foundation for sustained improvement and future expansion of patient safety efforts.

An area is designated as a national clinical safety priority when robust evidence shows that it requires a strategic, multiagency, coordinated, and resource intensive response. This includes indications of:

- potential or actual high impact harm
- outcomes that are outliers compared with similar nations
- significant or escalating litigation costs
- systemic failure marked by repeated, widespread issues
- persistent, widespread risk or disruption to the public.

National Clinical Safety Priorities

- **Acute physical deterioration** remains a significant safety concern, particularly where sepsis is not prevented, recognised or treated promptly. Delays in identification and escalation contribute to avoidable harm and greater pressure on hospital services. Implementing Call for Concern across NHS Wales will provide an additional route for early escalation, enabling timely intervention when deterioration is suspected. This will be complimented with a greater focus on sepsis.
- **Deconditioning in the community**, particularly for people living with frailty, increases the risk of falls and avoidable hospital admissions. Once in secondary care, these individuals often deteriorate further, leading to longer stays and greater pressure on hospital services. Addressing deconditioning early in the community is key to reducing preventable harm and demand on secondary care.

- **Health care associated infections (HCAIs)** remain a persistent patient safety challenge in NHS Wales, with variation in prevention practices, antimicrobial stewardship and environmental standards increasing the risk of avoidable harm. Pressures on staffing, estates and isolation capacity further limit the ability to maintain consistent infection control. Strengthening core prevention measures and ensuring more reliable systems for surveillance and response are essential to reducing HCAIs and improving patient outcomes.
- **Improving safety in secondary care mental health services** remains challenging, with inconsistent safety measurement and variation in practice across inpatient and community settings. Strengthening the use of clear safety metrics and patient reported outcomes such as ReQoL will enable more responsive, evidence based care and provide stronger assurance of safety, informed by national evidence and professional standards.
- **People with a learning disability and neurodivergence** in Wales continue to face unequal access to care and poorer outcomes, with persistent systemic barriers highlighted by national reviews. Families also report inconsistent communication and variable service quality across health and social care. These challenges demonstrate the ongoing need for more coordinated, person-centred improvement to ensure safer, fairer and more responsive services across NHS Wales.

- **Maternity and neonatal services** face persistent safety challenges, with the recent wholes system assessment identifying inconsistent triage and induction pathways, workforce pressures and gaps in postnatal and neonatal support. These vulnerabilities affect the quality and reliability of care experienced by women, babies and families across Wales. Strengthening critical clinical safety systems and ensuring more consistent models of care are essential to improving outcomes.

Development area:

- **Medicines safety** remains a significant challenge in NHS Wales, with variation in prescribing, monitoring and administration contributing to avoidable harm across services. Increasing clinical complexity and frequent care transitions heighten the risk of medication related errors and unmet therapeutic needs. Strengthening systems for safer prescribing and monitoring is essential, and medicines safety is a developing national priority area requiring further focus and coordinated improvement.

Each priority area will incorporate a focus on:

- connecting to, and building on, existing national programmes of work
- co-production and the involvement of people with lived and learnt experience
- safety culture with a Safety I and Safety II listening and learning approach
- standardisation and adherence to good practice (e.g. Quality Statements, NICE Guidelines)
- action to reduce health inequalities and data stratification to evidence impact
- experience and outcomes for the people of Wales
- a whole-system approach that connects across primary, secondary, community and social care to achieve self-sustaining change
- targeted improvements across the continuum of care from prevention to end of life care
- a lens on public protection and safeguarding
- the national and local Quality Management System to embed and sustain improvements
- economic evaluation of interventions

National governance structures will monitor delivery against the agreed priorities and be responsible for setting future priorities. Clinical areas will remain a national priority until data within the Quality Outcomes Framework, and ultimately the Health Outcomes Framework, demonstrates a sustained reduction in unwarranted variation and consistent delivery of high-quality care.

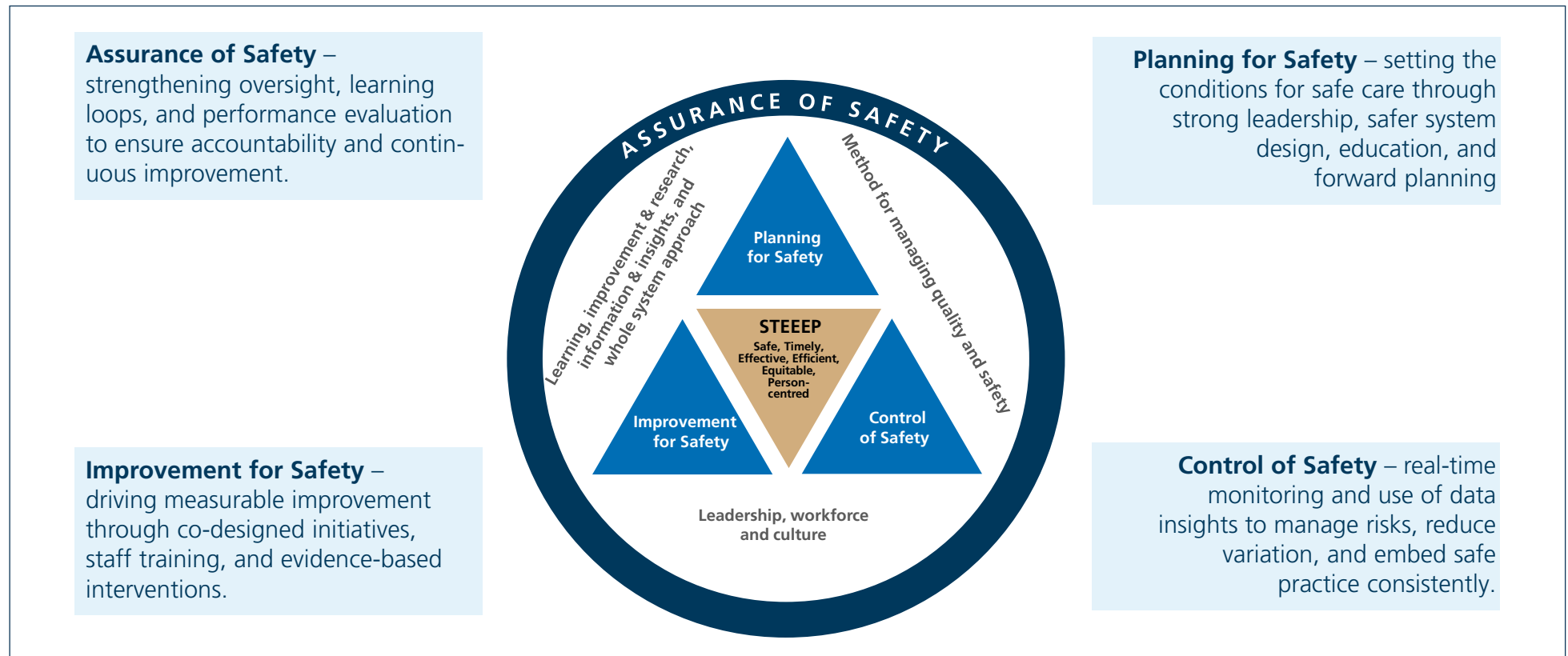
5. Strengthening System-Wide Patient Safety Across Wales

Safer care depends on a joined-up approach that connects planning, delivery and assurance across the whole healthcare system. A clear and consistent way of working is essential so that patient safety is embedded in every part of NHS Wales. Strengthening national connectivity through a shared operating model will support organisations to deliver safe, reliable care. A strengthened system wide approach must reflect the different organisational and contractual models across the NHS, ensuring that the safety of general practice, community pharmacy, optometry and dental services is integral to the national patient safety system, with Health Boards continuing to assure quality and safety for all contractor professions.

A Quality Management System (QMS) is the foundation for managing quality in healthcare, as described in the Duty of Quality and a QMS for Patient Safety provides the foundation for managing patient safety nationally to improve the safety of care in NHS Wales. It brings together four key elements, illustrated in Figure 1 below:

- **Planning for Patient Safety** – setting clear goals for safety and quality.
- **Patient Safety Improvement** – making changes that lead to better care.
- **Control for Patient Safety** – checking that standards are being met every day.
- **Patient Safety Assurance** – giving confidence that care is safe and effective.

Figure 1: QMS for Patient Safety



When these elements work together, they create a strong framework for delivering safe, high-quality care. Appendix 2 provides further detail on core components of each aspect of the QMS for Patient Safety.

Currently, learning and information can be fragmented, which slows down improvement and creates variation in safety standards. A QMS for Patient Safety provides a single, integrated approach that connects feedback from patients, staff and partners with data and national priorities. This means problems can be identified and fixed quickly and successful practices can be shared across the system. It also ensures that safety is not treated as an isolated activity but as part of everyday care.

Within General Medical Services, the Contract Assurance Framework (CAF) already operates as the Quality Management System for GMS. Explicitly recognising CAF within the national QMS provides coherence, prevents duplication and supports a whole system approach to safety across both directly provided and contractor delivered services.

A QMS for Patient Safety will make care safer by embedding patient safety into every decision and process. It creates a culture of continuous learning, supported by real-time feedback and clear accountability. It will help prevent harm, reduce variation and improve confidence for patients and staff. By focusing on what matters most, organisations can improve their systems and enhance ways of working, leading to better experiences and outcomes for everyone. Appendix 3 sets out the current National QMS for Patient Safety and actions in section 6 of the plan seek to simplify and strength the existing QMS and governance structure into a national patient safety system that continuously learns, improves and delivers safer care for all. The NHS Wales QMS Framework underpins this approach.

The quality management approach to patient safety aligns to effective clinical governance by delivering a focus on effectiveness, research, audit, workforce, culture, risk management, the effective use of information, staff training and education. It is supported by effective leadership and places the patient at the centre of high quality and safe care.

Translating a QMS for Patient Safety into practice at a national and organisational level transforms improvement efforts into a structured, integrated system that ensures reliability and embeds continuous learning across all services.

The approach has been proven by organisations such as East London Foundation Trust (ELFT), which since 2013 has leveraged a series of safety events to emphasize the need to embed the need for fundamental organisational change. This has resulted in impact such as a 30% reduction in inpatient physical violence and a 50% reduction in incidents of verbal aggression¹². At ELFT, these improvements in patient safety did not come from a single intervention, but from embedding quality into how the organisation was led, measured and managed.

Similarly, NHS Lanarkshire relieved pressures in Emergency Departments through a Whole System Quality approach embedded at every opportunity in the pursuit of improved and safer care¹³. Leeds Teaching Hospitals NHS Trust developed the Leeds Improvement Method to shift from quality assurance to a holistic QMS approach that led to measurable improvements such as reduced surgery cancellations and better medicines recycling¹⁴.

Developing a quality management system improves patient safety by making quality and safety system properties rather than individual responsibilities. The experience of the organisations cited above shows that when leadership, data, culture and capability are aligned through a QMS, healthcare organisations can achieve sustained reductions in harm and continuously improve the safety of care.

12 Institute for Healthcare Improvement (2026) **East London NHS Foundation Trust: Building a Culture of Improvement**

13 The Health Foundation (2025) **Developing whole-organisation Quality Management Systems in health care: learning from practice and recommendations for progress**

14 The Health Foundation (2025) **Developing whole-organisation Quality Management Systems in health care: learning from practice and recommendations for progress**



6. The Five-Year National Patient Safety Plan

Six enablers are recognised as critical to achieving patient safety across NHS Wales. They act as foundational drivers for change and are aligned with the Quality Enablers outlined in the Health and Care Quality Standards within the Duty of Quality.

These enablers represent the areas of greatest need and opportunity for improving patient safety and support the actions set out in this five-year Plan. They underpin the foundational pillars of Listening, Leading and Learning.

Each enabler is described below, supported by a high-level illustration and the detailed Plan. The descriptors and their actions are the result of research across international and national patient safety strategies, comparison with major reviews and assessments across the UK and globally, a gap analysis of the Welsh patient safety system and co-design with NHS Wales and Welsh Government (See Appendix 1).

Leadership



Visible, connected and accountable leadership is essential for setting expectations, aligning the healthcare system and modelling a culture of patient safety that listens and learns. By fostering a culture where leaders at every level champion patient safety, take ownership of outcomes and promote a just culture, trust is built throughout the organisation, ultimately leading to safer healthcare outcomes. Leaders understand the crucial role that staff experience plays in delivering safe care and ensure their leadership supports this.

Workforce



A resilient, skilled and digitally confident workforce is essential for delivering safe, efficient and consistent care. Developing and sustaining such a workforce ensures that staff are empowered and supported to provide high-quality care, equipped with the necessary skills and knowledge of patient safety to perform effectively at all levels, both now and in the future. Multi-disciplinary staffing across NHS Wales is crucial to consistently maintaining safe patient care.

Culture



A positive and just patient safety culture is fundamental to delivering safe, high-quality healthcare that reduces harm and inequities. Creating and sustaining such a culture means fostering an environment where openness, fairness and learning are the norm. It promotes psychological safety, civility, inclusivity and continuous learning, empowering all staff to speak up for patient safety and ensuring that lived and learned experiences inform improvements in care.

Information and Insights



Timely and accurate data is critical for preventing avoidable harm and improving healthcare quality. Developing and maintaining an integrated, real-time information system empowers healthcare teams by providing robust tools to collect, measure, analyse and share patient safety data effectively. By triangulating quantitative and qualitative measures of performance, experience and outcomes, the system supports continuous improvement, encompassing both traditional Safety I approaches and the broader, proactive Safety II perspective.

Learning, Improvement and Research



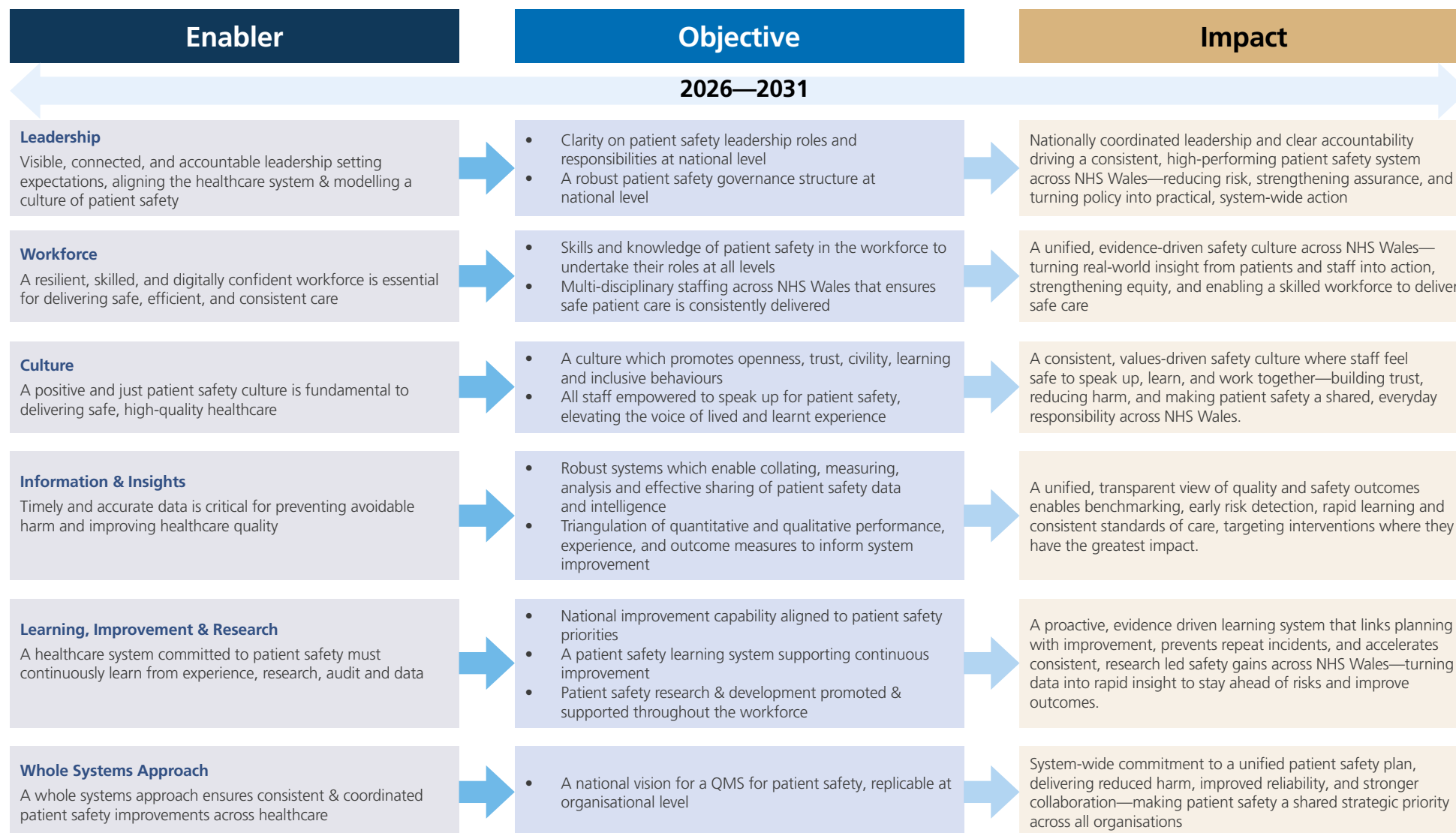
A healthcare system committed to patient safety must continuously learn from experience, research, audit and data. Establishing a dynamic learning system enables rapid conversion of insights into action, linking national improvement capabilities to patient safety priorities while drawing on the best available evidence. This supports a patient safety learning system that drives continuous improvement and promotes research and development across the workforce.

Whole Systems Approach



A whole systems approach ensures consistent and coordinated patient safety improvements across healthcare, reducing variation in outcomes. Implementing a national Quality Management System (QMS) approach provides a clear vision for patient safety that can be replicated at the local and organizational level, supporting uniform standards and continuous improvement throughout the healthcare system.

Figure 2: Summary of the Five-Year National Patient Safety Plan



The table below presents the five-year National Patient Safety Plan. Some of the Phase 1 actions are already underway and will continue to be developed and embedded within the healthcare system.

All actions will be led by NHS Wales Performance and Improvement, in partnership with national organisations, Welsh Government, health boards and trusts. An internal NHS Wales Performance and Improvement implementation plan supports the delivery of these actions.

Leadership

Objective	Action	Impact	Timeline
1. Clarity on patient safety leadership roles and responsibilities at national level.	1.1 Establish a National Patient Safety Team, with clear role descriptors, agreed ways of working and strong connectivity across NHS Wales.	Coordinated leadership, authoritative guidance and robust assurance at a national level—maximising system-wide learning, reducing risk and delivering visible leadership that translates policy into consistent, practical action across NHS Wales.	Phase 1 (2026-2027)
2. A robust Clinical Governance Framework at national level.	2.1 Establish a robust national Clinical Governance Framework, ensuring seamless connectivity between Welsh Government, NHS Wales organisations and local systems.	Strong national oversight, unified leadership and clear accountability driving patient safety through integrated planning, assurance, improvement and control - creating a consistent, transparent and high-performing safety system across Wales.	Phase 1 (2026-2027)

Workforce

Objective	Action	Impact	Timeline
3. Skills and knowledge of patient safety in the workforce to undertake their roles at all levels.	3.1 Design and develop a comprehensive Patient Safety Curriculum for all NHS Wales staff (clinical and non-clinical).	Consistent knowledge, skills and behaviours across clinical and non-clinical roles aligned with national safety strategies, standards, statutory duties and the latest safety science, which enables a unified safety culture and reduces preventable harm.	Phase 1 (2026-2027) - scoping Phase 2 (2027-31) – design/implementation
4. Multi-disciplinary staff across NHS Wales that ensures safe patient care is consistently delivered.	4.1 Develop a national framework for clinical excellence and digital, validated accreditation model that recognises and celebrates high quality care.	Strengthened system-wide readiness for workforce transformation providing a unifying, values-led approach that supports integration across services and professions.	Phase 1 (2026-2027)

Culture

Objective	Action	Impact	Timeline
5. A climate which promotes openness, trust, civility, learning and inclusive behaviours.	5.1 Adopt a national safety culture framework with practical tools to embed just and restorative culture, psychological safety, civility and inclusive behaviour.	Consistent, values-driven culture where staff feel safe to speak up, learn from incidents and collaborate effectively. Fosters trust, reduces harm and drives continuous improvement—ensuring patient safety becomes a shared responsibility and an everyday reality across NHS Wales.	Phase 2 (2027-31)
	5.2 Integrate robust safety culture assessments into the NHS Wales Staff Survey by embedding validated tools and targeted questions that capture how staff perceive and experience safety in their workplace.	Evidence-based picture of safety culture across NHS Wales, enabling organisations to benchmark performance, identify strengths and gaps and target improvements where they matter most. Fosters openness, trust and continuous learning.	Phase 2 (2027-31)
6. All staff empowered to speak up for patient safety and elevate the voice and experience of lived and learnt experience.	6.1 Adopt the NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations (2025) as a cornerstone of patient safety culture.	Drive a cultural shift across NHS Wales—placing listening, respect and accountability at the heart of care. Patients, families and staff feel heard and supported, while organisations turn feedback into meaningful action.	Phase 1 (2026-2027)
	6.2 Enhance and embed robust speaking-up mechanisms across NHS Wales by fully implementing the Speaking Up Safely Framework (2023) and Call4Concern.	Build psychologically safe environment where staff feel valued and protected when voicing concerns. Accelerate early identification of risks, prevents harm and drives continuous improvement. Strengthen teamwork, improves patient outcomes and embeds safety as a shared responsibility across the system.	Phase 1 (2026-2027)
	6.3 Implement the People’s Experience Framework to embed experiential data into organisational Quality Management Systems (QMS).	Transform feedback into actionable insight, ensuring care is shaped by lived experience as well as evidence. Build trust, enhance quality and create a culture where every voice contributes to safer, more compassionate healthcare across NHS Wales.	Phase 1 (2026-2027)

Information and Insights

Objective	Action	Impact	Timeline
7. Robust systems which enable collating, measuring, analysis and effective sharing of patient safety data and intelligence.	7.1 Implement the Quality Outcomes Framework (QOF) at both national and local levels, ensuring comprehensive coverage of patient safety priorities, creating a robust, integrated system for monitoring and improving safety performance across NHS Wales.	Unified, transparent view of safety outcomes at both levels, enabling benchmarking and identify emerging risks early. Drive evidence-based decision-making, accelerates improvement and ensure consistent standards of care.	Phase 1 (2026-2027) – phase 1 measures Phase 2 (20227-31) – further development
	7.2 Further develop and implement Beacon as a resilient digital and informatics system that enable real-time collection, analysis and sharing of patient safety data across NHS Wales.	Connected, transparent safety intelligence network supporting proactive risk management and rapid learning. Drive evidence-based decisions, accelerate improvement and foster a culture of openness and collaboration.	Phase 1 (2026-27)
8. Triangulation of quantitative and qualitative performance, experience and outcome measures to inform system improvement encompassing Safety I and Safety II.	8.1 Integrate data from multiple sources—such as incident reports, patient experience, clinical outcomes and workforce feedback—into a single, connected system uncovering patterns, systemic issues and contributing factors that transform raw data into actionable insights.	Triangulate diverse data streams to identify emerging risks early, understand what works well and target interventions where they will have the greatest impact.	Phase 2 (2027-31)

Learning, Improvement and Research

Objective	Action	Impact	Timeline
9. National improvement capability aligned to patient safety priorities.	9.1 Establish a dynamic, data-driven rolling programme of improvement that targets agreed national safety priorities, using real-time insights and evidence to prioritise interventions, monitor progress and adapt quickly.	Proactive, learning health system where improvement is continuous and informed by data. Strengthen the link between planning and improvement, accelerate measurable progress on national safety priorities and foster consistency across NHS Wales.	Phase 1 (2026-2027)
10. Develop a patient safety learning system to support continuous improvement	10.1 Adopt a comprehensive patient safety learning system that connects data, experience and improvement activities across NHS Wales.	Dynamic, system-wide learning environment where safety improvements are continuous and evidence-driven. Accelerate change, prevent repeat incidents and foster a culture of openness and collaboration.	Phase 1 (2026-2027)
	10.2 Develop and implement a new All Wales Concerns Response and Learning Framework to modernise how patient safety incidents and concerns are reported, managed and investigated.	Foster openness, collaboration and shared accountability. Prevent repeat incidents, accelerates improvement and strengthens trust among patients, families and staff.	Phase 2 (2027-31)

Learning, Improvement and Research (cont'd)

Objective	Action	Impact	Timeline
11. Patient safety research & development promoted & supported throughout the workforce.	11.1 Embed learning from routine patient safety data through structured academic evaluation into NHS Wales.	Transform raw data into evidence-based insights that inform policy and practice. Academic evaluation ensures improvements are grounded in robust research, accelerating system-wide learning and reducing harm.	Phase 2 (2027-31)
	11.2 Create strong partnerships for patient safety research and innovation by embedding academic expertise within NHS Wales organisations.	Build internal capability for evidence-driven improvement, fostering a culture where research and practice work hand-in-hand to deliver safer, more reliable care.	Phase 2 (2027-31)
	11.3 Strengthen formal mechanisms with academia to undertake primary research on emerging patient safety issues.	Rapid response to new and complex safety challenges through cutting-edge research. ensuring NHS Wales stays ahead of risks, drives innovation and continuously improves patient outcomes.	Phase 2 (2027-31)

Whole Systems Approach

Objective	Action	Impact	Timeline
12. A national vision for a QMS for patient safety, replicable at organisational level.	12.1 Articulate and communicate the vision and benefits of a National Quality Management System (QMS) for Patient Safety across NHS Wales.	System-wide understanding and commitment to a unified patient safety plan. Tangible benefits—such as reduced harm, improved reliability and stronger collaboration—foster alignment, accelerate adoption and ensure patient safety becomes a shared strategic priority across all organisations.	Phase 1 (2026-2027)
	12.2 Work with Health Boards, GMS clusters and contractor professions to strengthen the integration Contract Assurance Framework within the national patient safety system, including shared learning mechanisms and system level safety intelligence.	Alignment of assurance, improvement and safety intelligence which strengthens whole system coherence, enables proportionate, system-level aggregation of safety intelligence and supports meaningful triangulation of safety signals across primary, community and secondary care.	Phase 2 (2027-31)

Figure 3: Summary of the phased delivery of actions



7. Delivering the National Patient Safety Plan

Oversight of the Plan will be delivered through national governance structures, ensuring clear alignment with the wider national safety landscape and the clinical governance arrangements set out in the Clinical Governance Framework which has five objectives:

- Define the core components of clinical governance in Wales including the interface between NHS Wales and Welsh Government
- Ensure consistency and alignment with national standards, recognised best practice and prudent healthcare principles
- Provide clarity on roles, responsibilities, and expectations
- Support work to develop a culture of safety, excellence and continuous improvement and learning
- Enable benchmarking and assurance across Health Boards and Trusts

This approach provides a coherent and integrated oversight mechanism that connects Welsh Government, national bodies and local organisations, enabling consistent monitoring of progress, identification of emerging risks and coordinated action to support delivery. It also ensures that the Plan is embedded within established assurance processes, strengthening accountability, transparency and system-wide learning across NHS Wales.

A cornerstone of the Plan is the development and refinement of actions for Phases 2–5 in collaboration with stakeholders, staff and the public. Each action will follow a consistent operational template including deliverables, owners, milestones, dependencies, risks, and resources.

8. Measuring the Impact

The Plan will drive national clinical patient safety priorities, directly advancing the outcomes set out in the Quality Outcomes Framework and ultimately in the Welsh Government Health Outcomes Framework.

Impact is outlined in the high-level National Patient Safety Plan and will be monitored throughout implementation through a combination of quantitative and qualitative measures including:

- The QOF dashboard providing real-time data on quality outcomes
- Reviews at two-year intervals to assess progress, recalibrate priorities and ensure alignment with emerging evidence and system needs

The measurement process will not only assess outcomes but also feed insights back into the system to drive improvement and foster a culture of learning and resilience.





9. Conclusion

The National Patient Safety Plan sets a clear direction for making care in Wales safer and better. Over the next five years, NHS Wales will focus on building strong foundations—better leadership, a safer culture and smarter use of data—while creating a system that learns and improves every day.

This is not just about meeting standards. It's about working together across health boards, trusts and national bodies to prevent harm, share learning and use innovation, including digital tools and AI, to improve care. Patients and staff will be at the heart of this work, shaping decisions and helping us understand what matters most.

Our goal is simple: care that is safe, effective and fair for everyone.

By reducing harm, removing unnecessary variation and building trust through openness, we will create a stronger NHS that can meet today's challenges and prepare for the future.

Appendix 1: The Evidence and Principles Behind Our Plan

Initial background research was undertaken on international and national patient safety strategies and 12 key themes identified and cross referenced to the Health and Care Quality Standards.

This research was triangulated with findings from participation in a ‘Five Nations Management Systems for Safety Roundtable’, a thematic review of the Review of Implementation of Recommendations from Previous Inquiries into Healthcare Issues¹⁵, a comparison of the key themes in the 10 Year Health Plan for England¹⁶, the Review of Patient Safety across the Health and Care Landscape¹⁷ (focused on England), the Global State of Patient Safety 2025 report¹⁸ and the National Assurance Assessment of Maternity and Neonatal Services in Wales¹⁹.

In addition, a gap analysis of the current patient safety system in Wales was undertaken and identified opportunities to implement further improvements in Safety II, holistic patient safety incident reporting, incident management standards and oversight, national patient safety governance and defined leadership, effective reporting, national concerns investigations standards and a systematic approach to patient safety. This analysis is supported by similar themes noted by Healthcare Inspectorate Wales highlighting a “system under sustained pressure”²⁰ and a rapid review of patient safety culture themes commissioned by Welsh Government from national Executive Peer Groups.

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- 15 Thirlwall Inquiry (2024) **Review of Implementation of Recommendations from Previous Inquiries into Healthcare Issues**
 - 16 UK Government (2025) **Fit for the Future: 10 year health plan for England**
 - 17 Department of Health & Social Care (2025) **Review of patient safety across the health and care landscape**
 - 18 Illingworth J et al. (2026) **Global State of Patient Safety 2025**
 - 19 Welsh Government (2026) **The Path to Safer Beginnings in Wales: A national assurance assessment of Maternity and Neonatal care and services**
 - 20 Healthcare Inspectorate Wales (2025) **Annual Report 2024-2025**

A set of seven design principles guided the development of the Plan:

- **Alignment** - the Plan must align to existing NHS Wales strategies and policies – including the Health and Social Care (Quality and Engagement) (Wales) Act 2020²¹ and the A Healthier Wales Action Plan (2024)²² and complementary to the nationally agreed Quality Outcomes Framework. It also aligns with Prudent Healthcare²³ and Well-being of Future Generations²⁴.
- **Culture** – the Plan must focus on developing a culture of safety learning and improvement by setting the right conditions
- **Stakeholder engagement** – the Plan will be led by NHS Wales Performance and Improvement and developed through engagement with NHS Wales Performance and Improvement, quality and safety experts from across the UK, health board and trust strategic and operational patient safety leads, national partner organisations (including Llais who represent the public voice), HIW and policy makers
- **Practicality** – there will be reviews every two years to monitor progress and re-align goals as necessary (2027 and 2029)
- **Evidence-based** – the Plan will draw together evidence from literature alongside patient safety expertise and data insights
- **Multi-professional and whole-system** – the Plan will incorporate actions spanning the whole patient safety system – the Quality Management System - including clinical and non-clinical and be applicable to all professions
- **Replicable** – the Plan will enable development of a patient safety system which is replicable at a national and a local level

21 Healthcare Inspectorate Wales (2025) **Annual Report 2024-2025**, 6.

22 Ibid., 5.

23 Welsh Government (2016) **Prudent Healthcare: Securing Health and Well-being for Future Generations**.

24 Welsh Government (2015). **Well-being of Future Generations**

Appendix 2: Core Components of a QMS for Patient Safety

Planning for Patient Safety

A process for leadership to plan and prioritise the design and redesign of safety systems, policy, processes and services, procure and allocate resources and products and identify capacity and capability to meet population needs.

- A relentless focus on patient and service user needs, staff wellbeing and culture informed by internal and external feedback.
- Purpose aligned to need and integrated into daily work and improvements.
- Design resilient systems that mitigate work and cognitive overload and enhance performance reliability.
- Plan and design tailored patient safety education to learning needs, using insights from alerts, incidents, experience and identified hazards.
- Patients, families and advocates are partners in the design and implementation of safety initiatives and are supported to be active partners in their own care and safety.
- Senior leaders visibly support safety initiatives and proactively engage frontline staff in decision-making.

Improvement
for Patient
Safety

Standardised training and coaching incorporating established methodologies for continuous improvements in safety for our populations.

- Staff at all levels are given QI skills, support from safety experts and protected time to improve patient safety.
- Patient safety improvements are planned and delivered close to the frontline, working with staff, service users, families and carers.
- Patient safety improvement work is scaled up in line with national priorities and co-produced with multidisciplinary teams.
- Patient safety improvements must be measured to confirm they work, identify unintended effects and determine if further action is needed.

Control of
Patient Safety

Connected daily operational management to monitor and maintain patient safety, including the use of real-time measures over time.

- Understand how system conditions vary, identify what variation is helpful or harmful and adjust processes to stay resilient.
- Frontline teams create standard processes to improve reliability and reduce variation.
- Make real-time process corrections when needed and ensure clear escalation routes for safety concerns.
- Use visual tools to track trends and safety performance, helping identify issues early.
- Continuously identify, assess and reduce risks, with prompt responses and consistent reporting.
- Everyday work should be examined to understand hidden conditions, trade-offs and workarounds.
- Regular debriefing, especially after challenging situations, maximises learning.

A process to ensure that the system is operating effectively and providing safe care in line with standards, guidelines, policy and regulatory requirements.

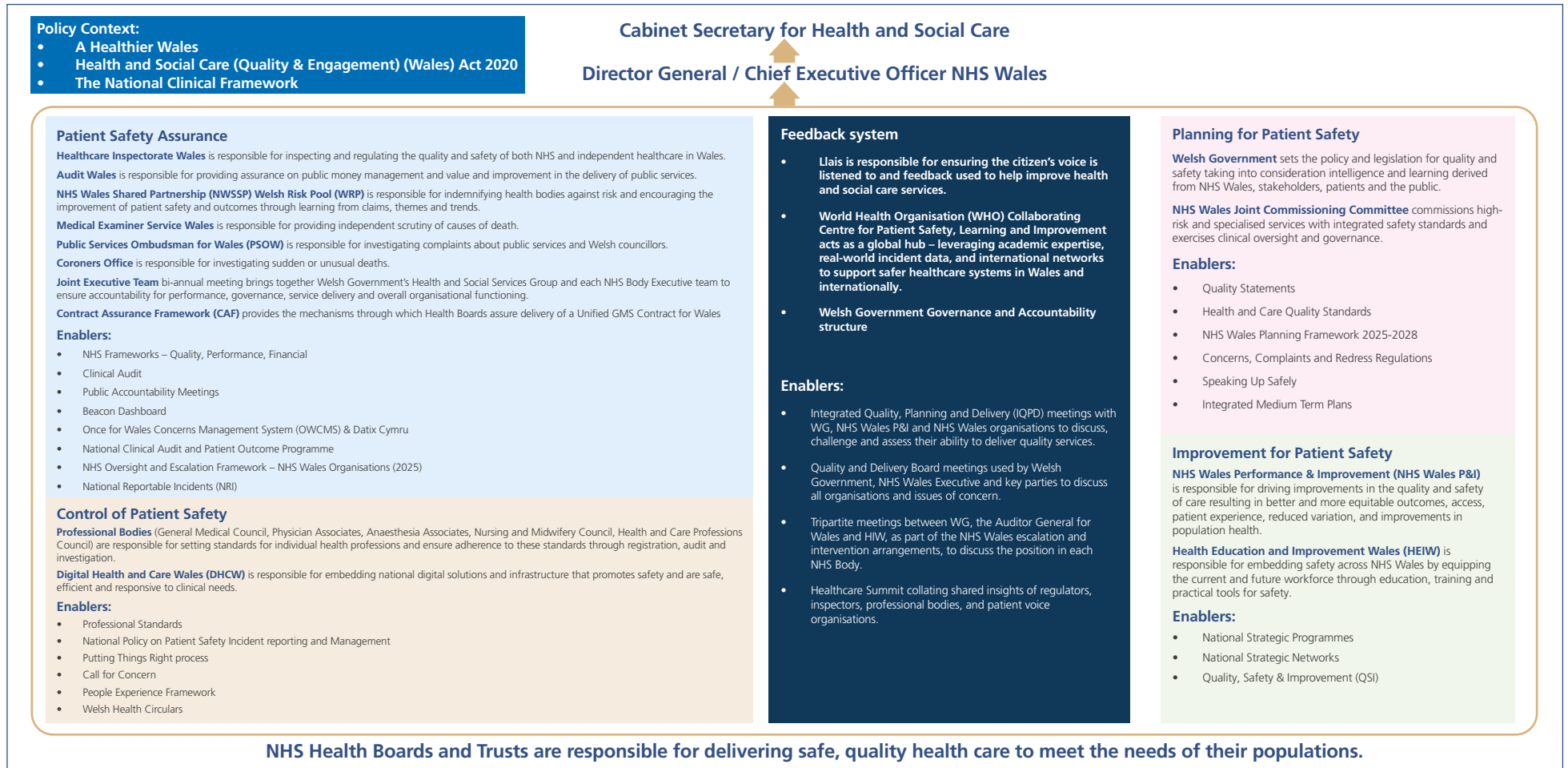
- Provides clear organisational visibility and accountability, creating a transparent line of sight from frontline to board supporting timely performance monitoring and action aligning with patient and service user needs.
- Uses comprehensive data and intelligence incorporating both retrospective and real-time analysis from internal and external sources to provide a robust evidence base for decision-making.
- Defines clear risk-escalation and response pathways, outlining how risks are identified, prioritised and escalated across the system.
- Drives continuous improvement through feedback loops transforming assurance findings into actionable learning, feeding insights back into planning and improvement processes.
- Aligns with statutory duties and regulatory oversight demonstrating compliance with the Duty of Quality and Duty of Candour while fostering a culture of openness and accountability that builds public trust.
- Delivers national assurance across the healthcare system through the oversight and monitoring of patient safety at local and national levels.
- Monitor national patient safety data and information supporting the identification of themes, trends and patterns along with early warning signals to identify emerging clinical risk/system level issues.
- Provides national escalation policies, frameworks and governance structures to enable early identification and intervention for local and system-level risks or performance issues.

Feedback System

Organisational learning to strengthen abilities that provide resilience, improve patient outcomes and enhance staff wellbeing.

- Robust system gathering feedback from patients, families, staff and partners.
- Use insights, intelligence and data to inform quality planning.
- Learning addresses both immediate issues and long-term change.
- Organisations use both informal learning and formal systems such as incident reporting.
- Learning from success and failure (Safety I and II) strengthens resilience and adaptive capacity.
- Double loop learning encourages deeper reflection and challenges assumptions behind complex problems.
- Storytelling supports shared learning, reflection and tacit knowledge.

Appendix 3: NHS Wales Current QMS and Governance landscape for Patient Safety



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