



10 Year Health Plan Patient Safety Learning's response

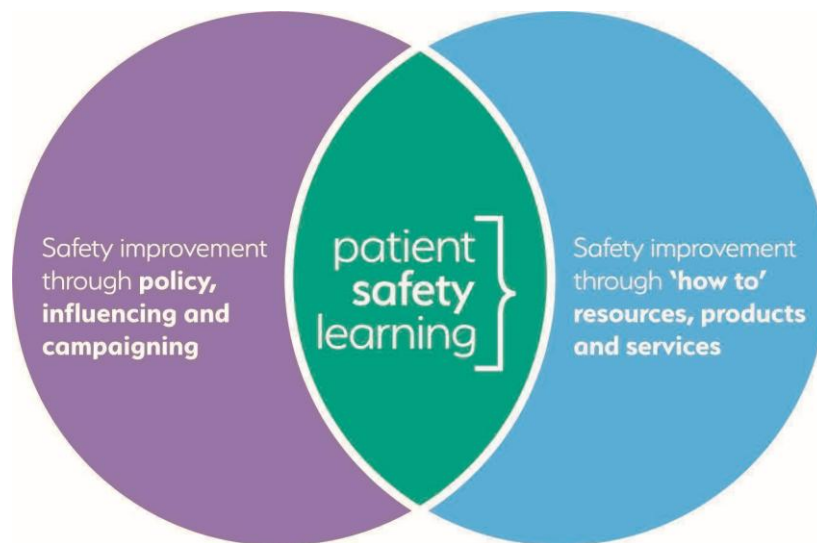
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Patient Safety Learning

Patient Safety Learning is a charity and independent voice for improving patient safety.

We harness the knowledge, enthusiasm and commitment of healthcare organisations, professionals and patients for system-wide change and the reduction of harm. We believe patient safety is not just another priority; it is a core purpose of health and social care. Patient safety should not be negotiable.

Through our work we support safety improvement through policy, influencing and campaigning, and the development of 'how to' resources such as the hub, our free award-winning platform to share learning for patient safety, and our unique Patient Safety Standards and support tools.



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Key messages

In our initial reflections on the 10 Year Health Plan, we highlighted that although it disappointingly does not recognise patient safety as one of its core themes, it does set out a welcome ambition to tackle some of the key underlying causes of avoidable harm.

In this response, we seek to elaborate this in more detail, setting out why patient safety needs to be at the core of the delivery of this new Plan. Much of the focus of our response concerns two of its three radical shifts: “Hospital to community” and “Analogue to digital”. We have not considered “Sickness to prevention” in detail, in recognition that many of the key aspects of this, such as legislative changes around the sale of tobacco and restrictions on junk food advertising, fall outside of our charity’s focus on patient safety.

We would not claim to have all the answers on how to ensure patient safety is designed into a new future vision of the NHS. Indeed, much of this will need to wait to be informed by the delivery plans that the healthcare system will be developing. We will respond on these issues as greater detail emerges.

Many of the issues we identify have been relevant for many years as the NHS has responded to other visions, plans and responses to inquiries into serious avoidable patient harm. Collectively, we should challenge ourselves to ask: Will it be different this time? Will the knowledge of the causes and contributory factors of avoidable harm be recognised and action taken to prevent future patient safety tragedies? Can we move from saying “never again” to making sure that lessons really are learned and action taken?

Below is a summary of our key messages that run through this response:

- We are disappointed that the 10 Year Health Plan does not identify patient safety as a key theme in delivering the three radical shifts in the NHS. We believe the risk and impact of avoidable harm to patients should be recognised as a strong driver of change. Patient safety is not just another priority; it should be a core purpose of health and care.
- Avoidable harm continues to persist at an unacceptable level. Every avoidable death and disability is an unnecessary tragedy for patients, families and healthcare professionals. It also comes at a huge financial cost. We must prevent avoidable harm to both reduce suffering and ensure funds are spent on services and not the associated enormous cost of unsafe care.
- There are not yet published delivery plans to go with this vision for the future of the NHS. Without these it is difficult to assess whether the 10 Year Health Plan’s ambition is likely to be realised and the significant and all too familiar patient safety concerns are addressed.
- Creating a Neighbourhood Health Service is an admirable ambition. It is a significant undertaking, and service redesign and plans should ensure that patient and staff safety is core to how care is delivered, how unnecessary hospital admission is prevented and early discharge is supported. Safety should not be an afterthought.

- If the NHS is to become a fully digitally enabled service, patient safety will need to be at the heart of the introduction, implementation and operationalisation of new technologies and innovations, particularly AI-enabled care.
- Cyber attacks present a significant risk to patient safety; one which will only grow with the increased digitalisation of health services. The absence of digital security from the 10 Year Health Plan is a serious omission; planning and investment in this area will be essential to its successful implementation.
- We welcome the Plan's ambition to make greater use of the NHS's data to improve services and we agree that there needs to be significant investment in digital and data capacity. However, we would note that a key problem remains: "the implementation gap". Even with the best data available, for any such system to be effective it must be matched by the appropriate mechanisms to act on its findings and subsequently check that these actions result in improvement.
- The Plan places a welcome emphasis on the importance of patient feedback and complaints, and the NHS App can undoubtedly be valuable here. However, we think there is important to acknowledge there is still an important a role for other sources of feedback, beyond an updated NHS App. This is particularly the case when it comes to patient safety concerns or poor patient experiences. Valuable learning and insights of this type can come from both inside and outside formal NHS processes.
- A strong emphasis is placed on patient choice in the Plan, but relatively little is said about the role of patient and public involvement in shaping healthcare services—beyond engagement through new digital portals. Coupled with the proposed centralisation of patient experience functions within the Department of Health and Social Care there are valid concerns this could act to weaken the strength and independence of the patient voice.
- The absence of considering and responding to problems with NHS culture is a significant oversight in the 10 Year Health Plan. One that, in our view, could jeopardise its delivery. Too often, at a national level, it appears that the extent and persistence of blame cultures in healthcare, and the need to tackle this, are simply not acknowledged. If the healthcare system is to truly be transformed over the next decade, then we cannot simply proceed by ignoring these issues or assuming they will resolve themselves.
- Coinciding with Dr Penny Dash's review of patient safety, we welcome the overarching recognition of the need to coordinate and rationalise the patient safety landscape in England.
- However, the proposed structural changes do not address the ongoing patient safety "implementation gap". They also do not tackle the absence of systematic approaches to sharing learning about avoidable harm, the inadequacy of joined up approaches and user-centred design in solution development. We need improvement action in the NHS at local and national levels to ensure that causes and contributory factors of avoidable harm are not just better understood but acted upon to prevent future tragedies.

Introduction

On 3 July 2025, the UK Government published its [10 Year Health Plan for England](#).¹ The Plan sets out how it intends to create a modern health service designed to meet the changing needs of the population. This report details Patient Safety Learning's response to the Plan, which makes the case that, if it is to achieve its aims, patient safety must be at the heart of its implementation.

Initially we consider how patient safety has been referenced in the 10 Year Health Plan and express our disappointment that it is not recognised as a key theme in the document. We then look at five key areas that we have identified as being crucial to the delivery of this Plan and highly relevant to patient safety:

- neighbourhoods
- digital health
- complaints
- performance and data
- patients and the public.

We subsequently highlight one key area, culture, which we were surprised to find was largely absent from the 10 Year Health Plan, but crucial to its success.

Finally, we set out the importance of having in place a safe healthcare system to underpin this Plan's delivery. We consider how taking a safety management system (SMS) approach to healthcare could support this, alongside the need for national structured systematic approaches to patient safety learning and solution development.

10 Year Health Plan

The 10 Year Health Plan identifies four major challenges shaping the future of healthcare in England:

- An ageing population living with multiple health conditions.
- Changes in illness, with more than a quarter of the population having a long-term health condition.
- Higher public expectations of how the NHS should provide services.
- Increases in cost, with health spending in England meeting the Organisation for Economic Co-operation and Development (OECD) average but achieving worse outcomes.

However, it notes that despite these challenges, there are reasons for optimism, stating:

“The NHS has unique advantages in seizing the opportunities that lie ahead. We stand at the cusp of an era where data and AI will fundamentally transform healthcare; where a digital healthcare revolution promises to unlock a new era of access and choice; where new discoveries in preventative medications offer to transform population health; and where genomics and predictive analytics will deliver an increasingly sophisticated understanding of individual health risk, powering a totally new approach to prevention.”

To take on these challenges, and act on the opportunities available, the 10 Year Health Plan reimagines the NHS through three radical shifts:

1. **Hospital to community**—envisioned by the initiation of “a historic expansion of provision in people’s neighbourhoods. By bringing more integrated services into local communities, patients will have more power to tailor care to their individual needs and more convenient access.”
2. **Analogue to digital**—transforming the NHS “from being a bricks and mortar service to a digitally led one, where patients can access care online and offline 24 hours a day, 365 days a year. By embracing the digital revolution, we will give patients the ability to control their appointments, choose their providers and access the help they need to manage their health and their care.”
3. **Sickness to prevention**—with a goal to “halve the gap in healthy life expectancy between the richest and poorest regions, while increasing it for everyone, and to raise the healthiest generation of children ever. This will boost our health, but also ensure the future sustainability of the NHS.”

Patient safety and the 10 Year Health Plan

While patient safety is considered at a few points in the new 10 Year Health Plan, it is not identified as a key theme in delivering its three radical shifts in the NHS. Coupled with the views expressed in the recently published [independent review of the patient safety landscape](#), it appears as though patient safety is instead seen as just one component of a broader approach to quality.²

The Plan does acknowledge the persistence of avoidable harm, pointing to numerous patient safety scandals over the past 25 years. It also highlights common themes associated with these:

“The failures that underpin each are consistent: incompetent leadership, toxic culture, rampant blame, workplace bullying, and a failure to learn from mistakes. There is also a fundamental lack of transparency, which means low quality or neglectful care does not come to light quickly; that the response is not fast or decisive enough; and that patient, staff and public attempts to sound the alarm go unheard.”

While we welcome the acknowledgment of these issues, we note that this focus on safety is specifically limited to the chapter “A new transparency of quality of care”. The term ‘patient safety’ itself is only mentioned 11 times in the 168-page document.

The relatively small role attributed to patient safety in the plan would seem to contrast with the current NHS England Strategic Risk Register, which identifies “care quality (safety, effectiveness and experience) for patients, carers and families” as one of its ten strategic risks.³ It states that the 10 Year Health Plan, aligned with other key documents, including a forthcoming new national Quality Strategy, would “set out system-wide priorities across safety, experience, and clinical effectiveness”. Patient Safety Learning is disappointed that this appears to have been given a lower level of importance in the 10 Year Health Plan.

We believe the risk and impact of avoidable harm to patients should be recognised as a much stronger driver for change. Too often, patient safety is typically seen as a strategic priority, which in practice will be weighed (and inevitably traded-off) against other priorities.⁴ To effectively tackle the persistence of avoidable harm, we believe it is important that patient safety is not just seen as another priority, but as a core purpose of health and care.

Persistence of avoidable harm

Our views on this stem from the fact that despite the growth in awareness of avoidable harm, and the hard work of many people in the health service, it continues to persist at an unacceptable level.

Prior to the Covid-19 pandemic, NHS England stated in the NHS Patient Safety Strategy that there were around 11,000 avoidable deaths annually due to safety concerns, with thousands more patients seriously harmed.⁵ Separately, a 2024 report from the Institute of Global Health Innovation has suggested that 13,495 lives could have been saved in the UK had it performed at the level of the top 10% of OECD countries.⁶

In practice, both these sets of figures are likely to be significant underestimates of the scale of harm given the ongoing enormous strain faced by the healthcare system in recent years. Particularly when also considering as part of this picture the pressures in service provision in primary care, emergency and urgent care and discharge planning with social care.

For example, in April last year, analysis by the Royal College of Emergency Medicine revealed that there were almost 300 deaths a week associated with long Accident and Emergency waits in 2023.⁷ Simultaneously, patients continue to face significant delays in care and treatment. Recently published data indicates that 2.99 million of the 6.23 million patients (48%) awaiting care have not had either their first appointment with a specialist or a diagnostic test since being referred by a GP.⁸ There can be serious patient safety implications for patients who remain for extended periods of time on waiting lists. Depending on their condition, this can have a significant impact on both their quality of life and, in some cases, their survival.

Every case of avoidable harm, every avoidable death and disability, is an unnecessary tragedy for patients, families and healthcare professionals. If unchecked, it can also undermine trust in our healthcare system. Patients, their families and the wider public will not tolerate, and rightly so, a healthcare system where they can see harm persist as a result of contributory factors that are well known but not addressed.

As the Government seeks to deliver on the vision set out in its 10 Year Health Plan, Patient Safety Learning believes that the scale of avoidable patient harm needs to be both acknowledged and tackled head on. It should not be an issue that is left to clinical leaders to resolve at local level but requires urgent system wide action.

Financial case for improving patient safety

The final chapter of the 10 Year Health Plan is dedicated to considering how the Government intends to put the NHS on a route to financial sustainability. It states that:

“Our aim over the next 10 years is to ‘bend the cost curve’ through a relentless focus on delivering value-based healthcare. Put simply, we will get far more out for what the taxpayer puts in ensuring every pound makes the maximum contribution to better outcomes, lower inequality and economic growth.”

Further to the human cost of avoidable harm, we would underline that the current scale of avoidable harm in the NHS also comes at a huge financial footprint. NHS Resolution figures alone make this clear. In their last annual report, they stated that:

- £3.1 billion was paid out in 2024/25 for compensation and associated costs on all of NHS Resolution’s clinical schemes, compared to £2.8 billion in 2023/24.
- The estimated ‘annual cost of harm’ for incidents in 2024/25 for the main clinical scheme, Clinical Negligence Scheme for Trusts, was £4.6 billion.
- NHS Resolution’s provision for future liabilities as of 31 March 2025 was £60.3 billion.⁹

Looking at the wider costs associated with patient safety, in 2022 the OECD estimated that the direct cost of treating patients who have been harmed during their care in high-income countries approaches 13% of health spending.¹⁰ Excluding cases of avoidable harm that may not be preventable, this figure is 8.7% of health expenditure.¹¹ In 2024/25, £181.4 billion

of the total Department of Health and Social Care budget was passed on directly to NHS England. Even saving 5% of this expenditure by reducing preventable harm would release £9 billion of funds to reinvest in service improvements and additional capacity.

The above figures do not account for the wider societal costs of avoidable harm, including the loss of productivity in the population as a result of people being economically inactive, either from the direct impact of avoidable harm to patients or the indirect impact to families, carers and employers.

The 10 Year Health Plan does touch on the issue of clinical negligence costs, noting that:

“We have asked David Lock KC to provide expert advice on the rising legal costs of clinical negligence claims, ahead of a review by the Department of Health and Social Care (DHSC) in the autumn.”

While we await this review’s findings with interest, we would underline that without safety improvements, funds that could be spent to proactively improve the volume, quality and safety of care will instead be wastefully spent on dealing with the cost of error and harm.

As noted in Dr Penny Dash’s recently published [*Review of patient safety across the health and care landscape*](#), the Department of Health and Social Care has spent at least £100 million on inquiries into safety in the last ten years.¹² These inquiries stem from failures in safety—they are the costs associated with a health system where avoidable harm persists.

There is a financial imperative, as well as a moral one, to focus on reducing avoidable harm in healthcare as part of delivering the 10 Year Health Plan.

Delivering the 10 Year Health Plan

If the 10 Year Health Plan is to achieve its aims, we believe that patient safety must be at the heart of its implementation. Considering how this relates to the content of the Plan, here we look at five key areas that are crucial to the delivery of the Plan and set out the importance of patient safety in relation to each of these.

1) Neighbourhoods

At the core of the 10 Year Health Plan is the creation of a Neighbourhood Health Service, where care takes place as locally as possible by default. It states that:

“It will bring care into local communities; convene professionals into patient-centred teams; end fragmentation and abolish the NHS default of ‘one size fits all’ care. It will transform access to general practice and prevent unnecessary hospital admissions. It will help reintegrate healthcare into the social fabric of places.”

Moving towards a more community-based model of healthcare is an admirable ambition, and also a significant undertaking. It will require a major investment in the redesigning of the healthcare system and its workforce if it is to meet its aim that the majority of outpatient care will have moved away from hospitals by 2035. The Plan talks about the creation of new services to deliver this:

- Single neighbourhood providers—these will deliver enhanced services for groups with similar needs over a single neighbourhood (c.50,000 people).
- Multi neighbourhood providers—these will deliver collaborative care across several different neighbourhoods (250,000+ people).

As care and treatment is transferred to these new providers, it will be imperative that their services are both efficient and safe. This will require clear plans to ensure they design in, develop and maintain effective systems and processes for safety and to respond to and learn from patient safety incidents.

Service redesign and plans should ensure that patient and staff safety is a core theme in how care is delivered, how unnecessary hospital admission is prevented and early discharge is supported. Safety should not be an afterthought.

The Plan also talks about these new providers sharing back-office functions. We think this should include support for delivering existing NHS patient safety initiatives such as the Patient Safety Incident Response Framework (PSIRF) and the Learn from Patient Safety Events (LFPSE) service. When it comes to learning from patient safety incidents, it is likely that issues and challenges that arise in one neighbourhood provider will occur in others. Therefore, it is important that learning and improvements are easily sharable between different neighbour providers at all levels.

Patient safety needs to be core to outcomes-based commissioning, ensuring that service providers prioritise and deliver safe and effective care.

Medication safety

When talking about neighbourhoods, the Plan also anticipates a significant shift in decision making when it comes to medications:

“Over the next 5 years, we will transition community pharmacy from being focused largely on dispensing medicines to becoming integral to the Neighbourhood Health Service, offering more clinical services. As community pharmacists increasingly become able to independently prescribe, we will increase their role in the management of long-term conditions, complex medication regimes, and treatment of obesity, high blood pressure and high cholesterol. We will also give community pharmacy a bigger role in prevention by expanding their role in vaccine delivery and in screening for risk of cardiovascular disease and diabetes.”

When considering avoidable harm in health and social care, unsafe medication practices and medication-related harms are one of its leading causes. Globally, harm due to medicines and therapeutic options accounts for nearly 50% of the overall preventable harm in healthcare.¹³ NHS England data indicates it accounts for about 10% of reported patient safety incidents in the NHS.¹³ Patients can be subject to avoidable harm in a range of different errors in parts of the process around medication, including:

- Prescription—patients can be underprescribed or overprescribed medicines for their condition, or receive a prescription that does not address their health condition and subsequently results in deterioration.
- Dosage—this can include missed doses or incorrect doses, which can occur in a range of settings, with a substantial proportion of these relating to children due to the complexity of weight-based paediatric dosing.
- Mistakes in the administration of medicine—such as administering a medicine which should be intravenous by the intrathecal route.

In a Neighbourhood Health Service the role of Community Pharmacists and Medication Safety Officers is likely to become increasingly important. We would particularly expect to see greater support and focus on groups such as the [Community Pharmacy Patient Safety Group](#) to support this transition in the safest way possible.

Outpatient services

As part of its neighbourhood proposals, the Plan aims for current services provided to outpatients (individuals who receive care at a hospital or clinic without needing to stay overnight) to shift into these new services. It states:

“Combined, these changes will contribute to our goal to end outpatient care as we know it. By 2035, most outpatient care will happen outside of hospitals. Digital tools will help people manage their care from the convenience of their home, with support from clinicians when needed.”

[In a recently published blog series on the hub](#), NHS rheumatology consultants Anne Kinderlerer and Benjamin Ellis highlight some of the key patient safety risks in outpatients and outline why these issues have been neglected by health systems.¹⁴ They describe how:

“Outpatient errors are typically situations where something has been missed, rather than something having been done to a patient, like a medication error. We see the same errors happening every day in outpatients: investigations that haven’t been scheduled, patients being ‘lost to follow up’ and scan results that haven’t been reported. There is often a delay between the error happening and the harm that it causes which makes recognition and reporting of errors harder and limits learning.”

Although these errors often cause harm, they are rarely reported and are often just seen as ‘something that happens’. Anne and Benjamin set out the reasons for this in their blog series, highlighting five important aspects of patient safety in outpatients. These issues, and the need to address them, will remain pertinent whether services are delivered in hospitals or new neighbourhood settings, and will require attention if avoidable harm is to be reduced.

2) Digital health

Digital advances, new technologies and innovations provide clear opportunities to improve patient care and outcomes. However, how they are introduced, implemented and operationalised can often raise new safety concerns and challenges that need to be anticipated and addressed.

The 10 Year Health Plan sets out a clear intention that “the NHS will become a fully digitally enabled service, operating 24/7 both online and offline.” Its ambition to use the Single Patient Record (SPR) to bring together a patient’s medical records in one place is a welcome one. In particular, it is positive to see that this includes proposals to ensure patients have access to this, with the Plan stating:

“We will make this possible through new legislation that places a duty on every health and care provider to make the information they record about a patient, available to that patient. We will also legislate to give patients access to their SPR by default. Subject to parliamentary time, our ambition is that from 2028, patients will be able to view it, securely, on the NHS App.”

Patients not only need easy access to their records, but simple mechanisms to flag concerns and address any inaccuracies in a timely manner. Mistakes in records can create significant patient safety risks, and [as illustrated by a recent patient experience shared with us on our patient safety platform the hub](#), amending these is often not a simple process.¹⁵

The Plan also includes welcome steps to improve digital processes for healthcare staff, including promising to introduce single sign-on for NHS software to remove duplication and reduce clinical time lost on repeated calls to IT helpdesks to reset passwords. Small changes such as this, accompanied by wider improvements of infrastructure, can help to improve patient safety. An example of where these issues cause problems can be seen in [our recent blog on corridor care and patient safety incidents](#), which considers how outdated and hard to use IT infrastructure can negatively impact the use of digital tools for incident reporting.¹⁶

Artificial intelligence

When discussing the application of new technologies in the NHS to improve patient care and experiences, the Plan places a particular emphasis on artificial intelligence (AI), stating that:

“This Plan will make the NHS the most AI-enabled care system in the world.”

At Patient Safety Learning we recognise the potential of the use of AI to improve patient care and outcomes. However, we would emphasise that patient safety considerations must be hardwired into the implementation of these solutions.

Patient safety must be at the heart of the initial procurement, design and configuration of new technological solutions provided by AI. As they are subsequently rolled out, any training or support required by staff to use these should be provided. Once in place, how they are operating in practice should be monitored; learning and acting on any risk assessments, incidents or near misses relating to this. In each of these stages, there should also be clear steps to involve and engage with both patients and frontline staff.

The Plan makes specific reference to the rollout use of ambient voice technology (‘AI scribes’) to reduce staff time spent on administrative tasks. This is an area where nationally the NHS has recently published guidance on the use of such products in health and care settings.¹⁷ While such products hold enormous potential in improving efficiency, how they work in practice needs to be monitored from a safety perspective, for example:

- Examining how accurately they understand medical terminology and capture subtle semantic differences. For example, confusing similar sounding medications.
- Checking for AI hallucinations—this is an issue identified in AI scribes where they generate text that is false, misleading or not based on what they have heard.¹⁸

The Plan also makes reference to AI being used in future to directly advise patients, stating:

“The My NHS GP tool will provide a single, trusted source of instant advice for patients who need non-urgent care, available 24/7. It will use AI-algorithms to take a patient’s descriptions of their worries or symptoms, ask the right follow-up questions and provide personalised guidance.”

We are pleased to see that in reference to this specific proposal, which would be a significant shift in the use of AI in healthcare, the Plan notes that safety would be paramount in any such move, with the system designed by clinicians. We would like to see this principle applied across all these new technologies.

Digital exclusion

The 10 Year Health Plan envisages a central role for the NHS App as the “front door” of the health service and notes that:

“Inclusion will be designed into the NHS App by default. We will tailor health information so it meets the needs of people from different backgrounds, and we will proactively identify people who may have lower digital literacy so their support needs can be addressed. Deaf people will be supported through British Sign Language accessibility, while blind and visually impaired people will be supported through screen readers.”

While this acknowledgement of the importance of inclusion is positive, this will ultimately be judged by whether the implementation of the Plan delivers this in practice.¹⁹ It will be particularly important to work with existing initiatives, such as the ongoing [Inquiry into Digital Inclusion and Health](#) being conducted by the Digital Poverty Alliance, to look at what practical steps are required to ensure that significant parts of the population are not left behind by these changes.²⁰

Cyber security

Cyber attacks present a significant risk to patient safety, one which will only grow with the increased digitalisation of health services.

This is recognised elsewhere as a key issue for healthcare with “Data and digital security” is identified as one of the ten strategic risks on NHS England’s Strategic Risk Register. The risk register emphasises that there “is a risk that malicious cyber actors deploy widespread, catastrophic cyber-attacks against the NHS leading to patient harm and/or data misuse causing knock-on financial consequences”.²¹ More broadly, the Government this year has published ambitions for a forthcoming Cyber Security and Resilience Bill, which will seek to improve UK cyber defences and regulation.²²

Given the 10 Year Health Plan has such a strong focus on digital health, we were surprised to find that cyber security is not mentioned in this document.

If this new Plan is to succeed in its aim of making the NHS “a fully digitally enabled service” then investment in cyber security is essential. NHS organisations need to not only focus on their own requirements but also be vigilant in checking the cyber security protocols of key system suppliers. Recognising these wider risks, in May this year NHS England published an open letter to suppliers to the NHS, encouraging them to sign up to a new cyber security charter.²³

When it comes to cyber security and patient safety, we believe it is important that:

- Organisations have robust business continuity plans to recover services, prioritising patient safety, so that if/when attacks do happen, they can be mitigated as soon as possible.
- There is clear communication with frontline healthcare professionals and patients if there are any disruptions, and there are plans are being put in place to address this.
- Learning from these incidents is shared widely both between Trusts and nationally to improve defences against future incidents across the NHS.

When responding to cyber attacks, NHS organisations need to be aware that, in addition to recorded cases of harm, incidents may have resulted in further patient harm that is more difficult to capture. Disruption caused by cyber attacks often results in significant delays to care and treatment, with longer waits having a particularly serious impact on patients with chronic conditions and worsening health. The impact of these delays will only be seen over time. Healthcare providers need to closely monitor any patient safety risk associated with these delays and ensure that there are appropriate escalation routes to minimise future harm.

These issues have been starkly illustrated by the ransomware attack on the Synnovis pathology system in 2024.²⁴ This saw more than a thousand operations cancelled as the laboratory used by two major hospitals, King’s College Hospital NHS Foundation Trust and Guy’s and St Thomas’ NHS Foundation Trust, was unable to report. One year on from this

event, the NHS confirmed that nearly 200 patients were harmed in connection with this attack and that in one case it contributed to a patient's death.^{25 26}

3) Complaints

The 10 Year Health Plan places a welcome emphasis on the importance of patient feedback and complaints. It identifies that the NHS faces a persistent problem with feedback systems and complaints processes that are often too far removed from the frontline and fail to translate into improvements.²⁷ It places particular importance on the NHS App going forward as a portal for patients to give their feedback on the care and treatment they receive. It also sets out the need to specifically improve complaints processes, stating that:

“For those who have concerns about the care they are receiving, we will significantly improve the complaints process within all NHS commissioners and providers. We will set clear standards for both the timeliness and the quality of responses to complaints and expect these to be handled within patient experience and patient complaints teams, not via PALS or external advocacy services.

When patients and their carers have patient safety concerns, we will expect a personalised, rapid response where managers and clinicians listen carefully, engage compassionately, provide answers to questions, explore whether care was provided to a high standard and learn continuously.”

Failure to act on learning from complaints is not a new problem, but one that emerges time and time again in patient safety investigations. We also identified this as one of the key policy areas where there are significant barriers to patient safety improvement in our report, [*Mind the implementation gap: the persistence of avoidable harm in the NHS.*](#)²⁸

We therefore welcome the Plan's ambition to improve complaints processes. Complaints made about healthcare are potentially a powerful source for learning about avoidable harm. Shortfalls in the quality and safety of care that result in a complaint can present an opportunity to identify where problems have occurred in existing processes and procedures, enabling remedial action to be taken to prevent their reoccurrence. Learning from feedback from patients, including formal complaints, can help to identify both issues local to an organisation and those with wider applicability across the health service.

We will also highlight here a couple of areas requiring further consideration concerning the Plan's primary focus on digital approaches to these issues.

First, the Plan indicates that patients will log feedback and complaints on the NHS App, then AI will be used to explore this data and “help to translate it into actions for managers”. This raises a number of questions about how this will work in practice, and specifically how effective AI can be in identifying patient safety concerns from these data. We have considered these questions in more detail in [our recent response to the new plans to develop an AI warning system to identify patient safety issues in the NHS.](#)²⁹

A second issue we note is that while in an ideal world patients would always use these new online systems to raise concerns, that may not always be the case. Particularly for patient safety concerns or poor patient experiences, people often do not feel comfortable or have confidence reporting this into a central NHS App. Even in this new vision of future NHS feedback, it is important to recognise the value that can be drawn from examining responses

to external groups such as [Care Opinion](#) on NHS services.³⁰ These can provide a potentially vital source of learning and insight.³¹

These are issues we would anticipate the new National Director for Patient Experience, announced as part of this Plan, would take leadership of in future.

4) Performance and data

A subject that runs across the 10 Year Health Plan is how the NHS can make better use of the data it holds to improve its performance. It states that:

“It has unparalleled data: The NHS has the best population health data in the world. It has extensive population coverage; it covers people cradle-to-grave; and it is not skewed by people’s ability to pay for healthcare. The NHS number is a powerful tool for data linkage across different settings. As healthcare becomes more data-driven, the NHS has a huge advantage.”

We welcome this ambition and agree there needs to be significant investment in digital and data capacity. The NHS could often be described as data-rich and information-poor, with access to a range of potential data sources but struggling to answer basic questions about how safe organisations are. This data should enable healthcare organisations to commission services for safety, particularly by paying greater attention to delivering improved outcomes and strengthening mechanisms for this, such as Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs). Both are essential for providing patient-centred care by incorporating patient perspectives into decision making.

One specific area where the Plan envisages the better use of data is the use of AI to detect patient safety concerns. Announced just prior to its publication, are plans to create an AI early warning system to automatically identify safety concerns across the NHS.³² [As we noted in our response to this announcement](#), we welcome any technological developments that can be applied to reveal the systemic causes of patient safety failure in a consistent and compelling way.³³ However, there are a number of questions about how this will work in practice, including:

- What data will this AI model be trained on? This will be critical to informing how it performs in practice. This can also affect bias and data, potentially overrepresenting certain groups or viewpoints, which can exacerbate and entrench health inequalities.
- Will these data include a patient’s clinical records? If so, how will patients provide consent for their data to be used in this way? Indeed, how will patient, family and carer insights be sought to inform such analysis? And how will staff-reported data, including whistleblowing testimonies, be captured?
- How much medical terminology will this new AI understand? Does it understand subtle semantic differences? This issue is currently being debated around the accuracy of AI-enabled ambient scribing software in taking patient records.
- How will alerts in the system operate? How will they be raised and to who? Will alerts be graded in severity?

Added to these questions, a key problem remains: “the implementation gap” —the difference between what we know improves patient safety and what is done in practice.³⁴ Even with the best data available, for any such system to be effective it must be matched by the appropriate mechanisms to act on its findings and subsequently check that these actions

result in improvement. We talk about this challenge in more detail in the next section of our response.

5) Patients and the public

In seeking to modernise the NHS, the 10 Year Health Plan sets out an ambition to place patients at the centre of this:

“There are 3 shifts, but only one core purpose: to put power in patients’ hands. By equipping patients with more choice and voice in the system, the most disadvantaged communities will have the agency and opportunities that better-off citizens take for granted.”

It places a strong emphasis on seeking to move towards a “patient-controlled NHS”, as mentioned previously placing particular focus on patient feedback via the NHS App. It talks about how digital tools will be utilised to support patients in being more active in the delivery of their own care and healthcare conditions.

We also welcome its specific focus on the importance of PROMs and PREMs, stating that:

“We will supplement quality metrics with patient reported outcome measures (PROMs). These are already in use in specialities like orthopaedics and mental health. They are powerful tools to measure the impact of care from the patient’s rather the clinician’s perspective. We will also collect patient reported experience measures (PREMs) in a more systematic and comparable way. By 2029, both PROMs and PREMs will be used universally, will be published in the public domain, and will be part of the data available to patients when choosing their provider on the NHS App.”

Patient and public involvement

While we welcome these measures, we would note that the Plan says relatively little about the role of patient and public involvement in shaping healthcare services beyond engagement through new digital portals. Where it does refer to this, it takes the form of a proposed new National Director of Patient Experience to bring the patient voice “in house”.

We set out our thoughts on this role in [our response to the independent review of patient safety across the health and care landscape](#).³⁵ While a new central body offers potential benefits for pooling expertise and resources, it will also be important to ensure this Directorate can benefit from regional and local experience and expertise. We would expect to see further detail setting this out in due course, including how the Directorate will connect with local models for engaging with patients, families and carers. Specifically, we would also seek clarity on how this Directorate will work with local and national Patient Safety Partners, whose are not mentioned in the 10 Year Health Plan or the independent review.

We also expect to see proposals on how the new Patient Experience Directorate will support and ensure that best practice in patient involvement and engagement is modelled and consistently implemented across the health system.

Patients can provide essential insights through a variety of roles in healthcare, including as:

- Educators—reinforcing professional values of caring, compassion and respect.
- Storytellers—sharing their experiences.
- Powerful advocates—gaining commitment to safer care from leaders, highlighting new risks and identifying improvement opportunities.
- Partners—strengthening the call for redesign and delivery for safer care.

For patients' insights to be valued and drive improvement they must be independent and supported to contribute to transformation and allowed to 'speak truth to power' as and when needed. Understandably, there are valid concerns that centralising patient experience functions within the Department may potentially act to weaken the patient voice.^{36 37}

We await more information about how these new roles can supplement the existing patient engagement arrangements throughout the NHS and be core to an invigorated patient safety culture.

Patient choice and inequalities

The Plan places a significant emphasis on patient choice, committing to introducing a new patient choice charter. Much of the focus of this is around digital developments, in particular improving the NHS App so that it becomes "a world-leading tool for patient choice". Its vision for this future includes features such as:

"Over time, and as outlined in chapter 3, the My Choices tool in the NHS App will allow patients to search and choose providers based on quality data - including length of wait, patient ratings and clinical outcomes."

When spoken about in public policy documents, "choice" is often characterised as a evidently positive development. While this may be true in theory, how this works in practice will often depend on each individual's background and circumstances. In seeking to increase patient choice as part of the 10 Year Health Plan, it is important that the NHS is conscious of how existing health inequalities may impact this.

This is related to the issue of digital exclusion mentioned previously in this response. For example, language can be a barrier to exercising a broader range of choices in a healthcare system. Difficulties in understanding information designed to enhance patient choice has the potential to result in some patients not having an equal opportunity to choose.³⁸

Another barrier, with specific reference to the proposed "My Choices" tool, could be encountered by patients who have limited numeracy skills and lower levels of health literacy. This could present difficulties in making decisions based on hospital quality data, factoring inevitable trade-offs between different aspects of this.³⁹ This may potentially entrench or even worsen existing inequalities within the health system.

The plan omits the need to tackle unsafe cultures

One issue we were surprised to find not heavily featured in the 10 Year Health Plan, and notable by its absence, is culture.

At Patient Safety Learning we identify creating a 'just culture' in healthcare as one of the six foundations of safe care in our report, [A Blueprint for Action](#), and as one of the core foundations of our Patient Safety Standards.^{40 41} A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution. We believe that it is vital that we create an environment in healthcare that supports raising, discussing and resolving concerns, with incidents of avoidable harm responded to with empathy, respect and rigour.

The Plan mentions 'culture' 17 times in 168 pages. When talking about patient safety at the beginning of its chapter "A new transparency of quality of care", it refers to toxic cultures being a key theme underpinning patient safety scandals. However, it says relatively little about what action will be taken to tackle these issues, only briefly talking about potential interventions for poorly performing NHS providers. Subsequently, the problems these issues drive have been acknowledged somewhat by the announcement of new proposals to regulate NHS managers.^{42 43}

However, we believe this is a serious gap that could jeopardise the delivery of the 10 Year Health Plan.

Persistence of blame cultures

As we set out in our [most recent analysis of the latest NHS staff survey results](#), there has been no significant change from recent years in responses to questions on reporting incidents, clinical safety and speaking up about patient safety issues.⁴⁴ While the survey provides an annual snapshot of what it is like to work in the NHS, its findings are reinforced by evidence elsewhere.

Blame cultures continue to be a recurring theme echoed across many different inquiries into major patient safety scandals and continue to persist in significant parts of the NHS. By creating an environment in which staff fear retribution if they are involved in a patient safety incident, blame cultures encourage staff to cover up the causes of avoidable harm rather than reporting them. There is significant evidence of clinicians being forced to become whistle-blowers and then often being treated with hostility when they raise genuine concerns about patient safety. We discuss these in more detail in our interview series, [Speaking up for patient safety](#).^{45 46 47}

Too often, at a national level, it appears that the extent of this problem, and the need to tackle it, is simply not acknowledged. This does appear to be the case in the 10 Year Health Plan.

NHS England has made some positive progress in introducing new guidance and information that aims to help organisations develop a safety culture in the NHS, as detailed in our report [We are not getting safer: Patient safety and the NHS staff survey results](#).⁴⁸ However, there is little detail about how to effectively implement safety culture guidance and best practice across NHS-commissioned health and social care providers. There is also a

lack of clarity about how improvements in culture will be monitored, evaluated and shared for wider adoption.

Patient Safety Learning believes the health service needs a more transformative effort and greater commitment to creating a safety culture. The existing network of Freedom to Speak Up Guardians working with individual healthcare providers will be able to contribute to a strengthened safety culture but this itself will not be sufficient. Organisations need to actively foster a patient safety culture, tackle blame and fear, and promote a culture of safety improvement.

Creating a safer healthcare system

Having considered a number of areas where patient safety is highly relevant to the delivery of the 10 Year Health Plan, Patient Safety Learning believes that if it is to achieve its aims then the wider healthcare system must be geared towards delivering safer healthcare.

The Plan itself envisions moving towards a leaner healthcare system, stating that under its new operating model:

“Our reforms will break with the past by pushing power out to places, providers and patients. The centre will be smaller, and its purpose will be clearer - not endless assurance and diktat to paralyse the rest of the system, but the facilitation of outcomes, partnerships and collaborative progress. This will be a culture shock for the NHS, but one that is fundamentally necessary.”

It talks about this new system having greater clarity of purpose around roles, fewer national targets and higher standards for leaders and provider organisations. It sets out that providers and commissioners will have their performance measured by clear metrics, with information made clearly available to empower patients.

Shortly after the release of the 10 Year Health Plan, Dr Penny Dash’s [Review of patient safety across the health and care landscape](#) was published.⁴⁹ Its findings and recommendations included a number of organisational changes intended to align with this vision of a leaner healthcare system specifically in relation to patient safety. As referenced earlier in this paper, [in our response to the Review](#) we have set out our reflections on these proposals in detail.⁵⁰

While we do not agree with the Review’s argument that patient safety has been significantly over prioritised in recent years, we do concur with its overarching recognition of the need to coordinate and rationalise the patient safety landscape in England. At the centre of this, the Review sets out a proposal to reinvigorate and repurpose the National Quality Board (NQB). It sees this as having a new coordinating role, responsible for developing a comprehensive strategy to improve quality of care (including patient safety) and operating a clearing-house function to co-ordinate and prioritise patient safety recommendations from national bodies.

However, we would assert that wider changes are needed if we are to move towards a safer healthcare system where the vision set out in the 10 Year Health Plan can flourish.

Implementation gap

One issue in particular that we believe remains unaddressed by these proposals is the “implementation gap” in healthcare.⁵¹

Referred to in the World Health Organization Global Patient Safety Action Plan as the “knowing-doing gap”, this is the difference between what we know improves patient safety and what is done in practice.⁵² This gap can emerge for a number of different reasons:

- Difficulties implementing changes across healthcare—it can be a complex task to change the ways of working and behaviour of many individuals and organisations.

- Patient safety guidance working in theory, but not in practice—actions that may appear to address patient safety issues failing to account for a wide variety of organisational context, culture and capacities.
- Insights and learning remaining in silos—patient safety improvements remaining locked in specific organisations, with a lack of means or commitment to widely share and disseminate new knowledge.

We have previously highlighted this issue in our report, [Mind the implementation gap: the persistence of avoidable harm in healthcare](#).⁵³ In this report we identify four common underlying themes associated with this:

1. Absence of a systemic and joined-up approach to safety.
2. Poor systems for sharing learning and acting on that learning.
3. Lack of system oversight, monitoring and evaluation.
4. Unclear patient safety leadership.

This challenge is not unique to healthcare. In other safety-critical industries, such as aviation, construction and nuclear power, eliminating causes of harm and prioritising safety is also of paramount importance. Though these industries differ significantly from healthcare, they face the same challenges in terms of translating the investigation and analysis of safety incidents into practical improvements. However, these industries are often far more effective at adopting a systems approach to this issue and ensuring that safety science and human factors inform user-centred design.

New proposals for an expanded role for the NQB could go some way to addressing these issues when it comes to national patient safety recommendations, with its proposed clearing-house function previously mentioned. However, as highlighted in our response to the [Review of patient safety across the health and care landscape](#), much of this will depend on how this is prioritised and implemented.

For the NQB to meet the new aims set out by the review it would require a significant change in how it operates and an increase in its capacity if it is to make a meaningful difference. This will be needed to undertake an expanded role in monitoring the implementation, and potentially evaluating the impact, of system wide safety recommendations. In undertaking this more prominent role, greater transparency would be also welcome. Minutes from the NQB's meetings in the last 12 months were only published on the day this review itself was released.

If this capacity and resourcing is in place, a revitalised NQB could make a significant difference to patient safety in the NHS. However, to create a safer healthcare system more broadly, a wider approach is needed. When considering this, we think the Department of Health and Social Care should look increasingly at the growing debate about the potential benefits that could be gained by moving towards a safety management system (SMS) approach in healthcare.

Safety management system

SMSs are an organised approach to managing safety, which are used widely in different industries. The purpose of an SMS is to ensure that an industry achieves its business and operational objectives in a safe way and complies with the safety obligations that apply to it.⁵⁴ A SMS has formal risk management processes for identifying hazards, mitigating and managing residual risk with safety policy and objectives, safety risk management, safety assurance and safety promotion. The Health Services Safety Investigations Body (HSSIB)

published a report last year considering the potential for implementing an SMS approach in healthcare.⁵⁵

At an organisation level, we would envision a SMS to include the following features:

- Board and Chief Executive accountability and engagement for safety, not just designated Patient Safety Specialists. Safety should be a formal agenda item at every Board meeting and given the same priority as performance and financial targets.
- Organisations owning a proactive approach to assessing and managing risk, not just waiting for an external regulator body to inspect and tell them whether they are safe or not. Organisations should take their own view of risk and assess and act on the balance between safety, efficiency and resource application. Discussions with regulators should then focus on whether organisations are effective in designing and delivering safety systems that lead to improvement, with subsequent inspections to verify this, making recommendations for improvements as required.
- A health system that is designed for safety, with standardised good practice and forcing functions that prevent avoidable harm, not just relying on staff creating workarounds and changing their behaviour to compensate for unsafe systems.⁵⁶
- A culture where safety is embedded, with behaviours that value insights, driving out a punitive approach where staff are castigated for speaking up.
- A culture that recognises the value of listening to the patient, family and carer voice. Patients should be engaged for safety at the point of care, if things go wrong, in improving services, advocating for changes and in holding the system to account.
- Steps taken to ensure that there is sufficient organisational capacity to deliver safe and effective care.

There would also be value in developing a SMS approach at Integrated Care System (ICS) level, ensuring an integrated and coordinated approach to safety, reflecting patient care pathways across systems and ensuring consistency and collaboration. In our report, [*The elephant in the room: Patient safety and Integrated Care Systems*](#), we highlighted how in the creation and initial development of ICSs there has been little mention of their role in, or impact on, patient safety.⁵⁷ A SMS approach would be one way of addressing this gap, with ICSs taking a leadership role for system safety and commissioning for outcomes, including safe care.

A further step would be to consider a SMS structure at a national level. This would seek to provide a more structured and joined up approach to patient safety strategies, involving all the national bodies with clarity of purpose, role and coordination. We believe that taking a SMS approach at an organisation, ICS and national level would benefit from further exploration by the Department of Health and Social Care, and that all organisations should have a clear safety remit within such a coordinated framework.

National learning and improvement

As part of looking at creating a safer healthcare system more widely, we also think there needs to be structured systematic approaches to learning about avoidable harm that leads to solution development and improvement action in the NHS. This is not featured in the 10 Year Health Plan, or in the Dr Penny Dash's [*Review of patient safety across the health and care landscape*](#), as we noted [*in our response to the latter last month*](#).⁵⁸

NHS England and the role of the National Patient Safety Team was not considered as part of the review by Dr Penny Dash, although it will undergo significant changes as its functions

are merged into the Department of Health and Social Care.⁵⁹ The National Patient Safety Team is currently responsible for owning various patient safety programmes and policies and issuing warnings and recommendations. However, what it lacks is significant capacity to intervene if necessary for the purposes of improvement, to commission or itself develop solutions that all organisations can use and adapt to improve.

This is not a role that is filled by any other body in the current patient safety landscape in England and results in each organisation that provides an NHS service (for instance, an acute, mental health or community trust, primary care service or hospices) having to 'reinvent the wheel' and create improvements just for their own directorates, services or organisations. The previous role and grant funding by Patient Safety Collaboratives of quality improvement initiatives appears to have ceased. This is inefficient and does not share knowledge on how to provide safer care and support for those committed to implementing solutions. This means avoidable harm will not be addressed consistently or speedily.

If healthcare providers identify a systemic issue that needs to be addressed because it affects other organisations, there is currently no national organisation that has the role or capacity to commission or design improvements and provide implementation guidance. Instead, organisations are left to find local solutions to system-wide concerns without a vehicle for widespread dissemination and evaluation.

We believe this gap places a serious limitation on the healthcare system's ability to reduce avoidable harm in healthcare. It does little to address the inconsistencies in care across the country, with multiple different responses and workarounds to system-wide problems with varying levels of success. It is also a significant missed opportunity if we fail to take learning gained from provider organisations and apply this nationally for improvement in a meaningful way.

The current role of the patient safety directorate of NHS England has not been designed to fulfil this role. It is unclear with the merger of the NHS England and the Department of Health and Social Care where the system leaderships for patient safety will sit and whether this championing and coordination of learning and safety improvement will be a priority at all.

Conclusion

While direct references to patient safety in the 10 Year Health Plan are limited, delivering safe care underpins many of the key ambitions included in this.

For two of its three radical shifts, "Hospital to community" and "Analogue to digital", the transformations envisaged by the Plan cannot be achieved in an unsafe system. In making a significant shift towards a Neighbourhood Health Service, safety cannot be an afterthought; it must be a core theme in user-centred service redesign and delivery. Likewise, if the NHS is to become a "fully digitally enabled service", safety needs to be a golden thread running from procurement of new technologies and innovations through to their implementation.

In our response to the Plan we have not touched on the third shift, "Sickness to prevention", in recognition that many of the key aspects of this, such as legislative changes around the sale of tobacco and restrictions on junk food advertising, fall outside of our charity's focus on patient safety. However, we recognise, and would welcome, the goal of improving overall population health as a means of creating a more sustainable healthcare system in the future.

In our view, the absence of culture in the 10 Year Health Plan is a significant oversight that could jeopardise its delivery. Too often, at a national level, it appears that the extent and persistence of blame cultures in healthcare, and the need to tackle this, are simply not acknowledged. If the healthcare system is to truly be transformed over the next decade, then we cannot simply proceed by ignoring these issues or assuming they will resolve themselves.

Further to the importance of patient safety being embedded throughout the delivery of the 10 Year Health Plan, we have also sought here to emphasise that to achieve this requires a move towards a safer healthcare system. While we welcome the Government's intentions to coordinate and rationalise the patient safety landscape in England, this alone will not achieve this. Moving towards a broader SMS approach in healthcare is a step that needs to be embraced and actioned. This must be coupled with structured systematic approaches to learning about avoidable harm that leads to solution development and improvement action in the NHS.

Much of the ambition of the 10 Year Health Plan is welcome and is potentially a significant turning point for the NHS. However, many questions remain about what its implementation will look like and the impact on patient safety. As we discussed earlier in this response, the small role attributed to patient safety in this plan seems to contrast with the status safety is given in importance on the NHS England Strategic Risk Register. We believe that there would be value in developing a patient safety risk assessment and management plan for the delivery of the 10 Year Health Plan.

We await the publication of a more detailed plan about how the 10 Year Health Plan will be delivered and initial areas that will be prioritised. We will reflect and respond on the patient safety issues as this delivery plan emerges.

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