Review of patient safety across the health and care landscape
Patient Safety Learning's response (16 July 2025)

About us

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 that patient safety is not just another priority; it is a core purpose of health and social care. Patient safety should not be negotiable.

Throughout 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.

Review of patient safety across the health and care landscape

On 7 July 2025, the Department of Health and Social Care (DHSC) published the findings of a review of patient safety across the health and care landscape in England.[1] This review was commissioned by the Secretary of State for Health and Social Care on the 15 October 2025 with the following purpose:

"The primary task of this review is to assess whether the current range and combination of organisations delivers effective leadership, listening, learning (including investigations and their recommendations) and regulation to the health and care systems in relation to patient and user safety (and to what extent they focus on the other domains of quality).

Based on this assessment, the review should make recommendations on whether greater value could be achieved through a different approach or delivery model.

The review will set out the wider landscape of quality, looking at health and social care. The mapping work will provide context for the review of the specific organisations named below. This work will also be used to more widely inform the 10 Year Health Plan."[2]

The review looked at six specific organisations involved in assuring and contributing to the safety of care: Care Quality Commission (CQC), National Guardian's Office, Healthwatch England and the Local Healthwatch network, Health Services Safety Investigation Body (HSSIB), Patient Safety Commissioner for England and NHS Resolution.

Its final report issued nine recommendations for change:

1. Revamp, revitalise and significantly enhance the role of the National Quality Board (NQB).
2. Continue to rebuild the CQC with a clear remit and responsibility.
3. Continue HSSIB's role as a centre of excellence for investigations and clarify the remit of any future investigations.
4. Transfer the hosting arrangement of the Patient Safety Commissioner to the Medicines and Healthcare products Regulatory Agency (MHRA), and broader patient safety work to a new directorate for patient experience within NHS England, transferring to the new proposed structure within DHSC.
5. Bring together the work of Local Healthwatch, and the engagement functions of integrated care boards (ICBs) and providers, to ensure patient and wider community input into the planning and design of services.
6. Streamline functions relating to staff voice.
7. Reinforce the responsibility for and accountability of commissioners and providers in the delivery and assurance of high-quality care.
8. Technology, data and analytics should be playing a far more significant role in supporting the quality of health and social care.
9. There should be a national strategy for quality in adult social care, underpinned by clear evidence.

Key takeaways

This briefing paper sets out in detail Patient Safety Learning's response to the findings and recommendations of this review. This can be summarised as follows:

Where we agree

- The review's assertion that the past 5–10 years have not seen a significant improvement in patient safety. Despite the hard work of many people and organisations, avoidable harm continues to persist at unacceptable levels.
- There is a need for a strategic focus improving the quality of care, including patient safety. Relatively little support goes to the day-to-day management and improvement of care.
- Its recognition that quality is multi-dimensional. It includes safety, effectiveness and patient experience, accessibility, equity and efficiency.
- There is a need to better assess and manage the balance of risks within organisations and across systems. This includes better cost-benefit analysis of actions to improve the quality of care and ensuring that there are no unintended consequences to patient safety of poorly implemented recommendations.
- The current system for complaints and concerns is confusing and lacks responsiveness, as has been identified in many reports in the last two decades.
- There is a need to coordinate and rationalise patient safety roles and responsibilities.

Where we disagree

- The review's argument that patient safety has been significantly over prioritised in recent years at the expense of other aspects of quality. We do not believe the examples given provide compelling evidence of this.
- The review's suggestion that spending on patient safety inquiries is evidence of a system that over prioritises patient safety. Inquiries stem from failures in safety. It is not credible to suggest that this expenditure equates to investment in safety improvement. Inquiries do not represent an investment in improving patient safety,

they are instead seeking to provide a better diagnostic of why harm occurs. We need to address the cause of avoidable harm not just understand why it happens.

Proposals and suggestions we welcome

- The recommendation to reinvigorate and repurpose the NQB. In particular, the suggestion that the NQB should be responsible for developing a comprehensive strategy to improve quality of care (including patient safety) and the need for a focus on improvement and innovation.
- The retention of the role of the HSSIB as expert investigators. We would like to see further detail on how its operational independence is maintained as it transitions to the CQC and in what form its valuable education programmes will continue.
- The creation of a new National Director of Patient Experience, also referenced in the 10 Year Health Plan. We look forward to seeing more detail of the scope and responsibilities of this role alongside a new Patient Experience Directorate.
- The emphasis on the use and importance of Patient-Reported Outcome Measures (PROMS) and Patient-Reported Experience Measures (PREMs).
- Support for effective risk-informed decision making with organisation boards responsible for all areas of performance. We believe patient safety has to be a core purpose, not one priority of many, and with clear accountability for patient safety in all roles across the whole organisation.
- Acknowledgement of the value of embedding a culture and capacity for continuous improvement.
- Recognition of the need for significant investment in digital and data capacity, alongside a strategy for using technology effectively.
- Recognition that there should be a national strategy for quality in adult social care.

Areas that need further review and consideration

- We believe there needs to be a transformative effort and commitment to creating a safety culture in the health service. We are disappointed that culture has not been a key issue considered by this review. There are significant changes needed to ensure that there is an open and fair culture with a focus on learning and improvement that does not blame healthcare staff for systemic failings. The existing network of Freedom to Speak Up Guardians working with individual healthcare providers is identified by the review as being able to contribute to a strengthened safety culture. However, this is not in itself sufficient. Organisations need to actively foster a patient safety culture, tackle blame and fear and promote a culture of safety improvement.
- One significant gap in the current patient safety landscape in England is the lack of structured systematic approaches to learning and solution development. In the absence of this, insights from good practice and investigation into patient safety incidents tend to be retained solely within individual organisations. Lessons learned need to be disseminated for rapidly resolved improvement, as recommended by the review.
- We have significant reservations about the role of Patient Safety Commissioner being transferred to the MHRA and the impact of this on the role's credibility and independence.
- Currently everyone who uses or works in the healthcare system, including patients, families, carers and healthcare staff, can raise issues that HSSIB may seek to investigate. We would like to see a commitment to retain this in some form as HSSIB transitions into its new hosting arrangement with the CQC.
- The review does not reflect on the future role of NHS England/DHSC on patient safety, nationally nor regionally, other than in chairing the reinvigorated NQB. National NHS leadership, arm's length bodies, system and professional regulators, Royal Colleges, standard setting organisations, peer review bodies, advocates and advisory bodies, commissioners and providers, etc, should be designed into an

effective operating model for quality and patient safety. This is an area where the revitalised NQB could take a leadership role in future. This would involve designing this into an effective safety management system, with clarity of each organisation's role and contribution to the reduction of avoidable harm.

- Although the review recognises that the quality of social care needs to be addressed, no specific recommendations are made in relation to this.
- There are a number of recommendations, that if not implemented as intended, might diminish independent voices in raising concerns about patient safety. It is essential that patients, families, carers, and staff can speak up and be listened to.

Reforming the patient safety landscape

The new review of patient safety across the health and care landscape in England paints a picture of a fragmented system that lacks coordination. Patient Safety Learning agrees with this assessment, which aligns with our position previously stated in *The elephant in the room: Patient safety and Integrated Care Systems*.[3] The existing structure of our health system is often ill-suited to tackling complex challenges to patient safety and addressing the underlying systemic causes of avoidable harm.

The review asserts that over the past 5–10 years we have not seen a significant improvement in patient safety. We would agree with this and go further, suggesting that there has not been a significant improvement in overall safety in the last 25 years, as envisioned from initiatives, including the NHS National Patient Safety Strategy published in 2019.[4] Despite the hard work of many people and organisations, avoidable harm continues to persist at unacceptable levels in the NHS.

We therefore welcome the recognition of the need to coordinate and rationalise patient safety roles and responsibilities in England, and in particular the following points made in this review:

- Its assessment of the need for strategic focus on care delivery and management to improve the quality of care, including patient safety. There is relatively little focus and support for the day-to-day improvement of care. As we said last year in our formal submission to the review, we believe a safety management systems (SMS) approach in healthcare should be explored, with a far greater use of standardised operating processes.[5]
- Its recognition that quality is multi-dimensional. It includes safety, effectiveness and patient experience, accessibility, equity and efficiency
- The need to better assess and manage the balance of risks within organisations and across systems, including better cost-benefit analysis of actions to improve the quality of care to ensure that there are no unintended consequences to patient safety of poorly implemented recommendations.
- Its acknowledgement of the need for a joined-up approach to safety recommendations. It includes a specific proposal to create a clearing-house function to prioritise existing and new safety recommendations.
- Calls for greater use of technology, data and analytics to significantly improve the safety, effectiveness and responsiveness of care delivery.
- Highlighting the need for a national strategy for quality in adult social care, underpinned by clear evidence.
- Its recognition that the current system for complaints and concerns is confusing and may lack responsiveness, as has been identified in many reports in the last two decades.[6]

However, we strongly disagree with an underlying argument that is set out early on in this review; namely, that patient safety has been significantly over prioritised in recent years at the expense of other aspects of quality. We think that the patients, service users and their families who have experience of avoidable harm and deaths would expect an even greater priority on patient safety.

Safety versus other areas of quality of care

"Finding 1: there has been a shift towards safety (vs other areas of quality of care) over the last 5 to 10 years, with considerable resources deployed, but relatively small improvements have been seen"

To support this statement, the review highlights a range of statistics and figures, including:

- The increase in the number of organisations and professional bodies established to consider different aspects of safety.
- Safety recommendations having "potentially contributed" to growth in hospital staffing and funding over the past 10 years.
- Increases in the numbers of manager nurses in the NHS.

The review states that this has been accompanied by "limited progress in improving safety" and has come at the expense of increasing resources in other areas, such as effectiveness, user experience and equity. It concludes by stating:

"It appears that a focus on safety over the last 5 to 10 years has been to the detriment of other aspects of quality of care, particularly effectiveness."

Patient Safety Learning would agree that, despite the hard work of many people and organisations in the health service, there has not been a significant improvement in overall safety in the past 5–10 years. Avoidable harm continues to persist at unacceptable levels in the NHS.

However, the examples given here to demonstrate evidence of an over-focus on patient safety appear somewhat ad-hoc. The report focuses on staffing levels (are fewer staff really needed to reduce unsafe care?) and the creation of relatively small healthcare bodies, such as the National Guardian's Office, HSSIB and Patient Safety Commissioner. The report did not address *why* initiatives to address avoidable harm have not succeeded and make recommendations to address these.

We do not think this assessment that safety has been over prioritised is particularly convincing.

Avoidable harm remains a real and consistent problem. Every avoidable death and disability because of avoidable harm is an unnecessary tragedy for patients, families and healthcare professionals. Tackling this goes hand in hand with creating a more effective and user-focused health system.

Patient Safety Learning will continue to make the case that patient safety needs to be at the core of health and care. We will set this out in further detail when responding in full to the Government's 10 Year Health Plan in the coming weeks.

Cost of safety

We also think it is important to challenge the review's assessment of the cost of safety as evidence of this perceived over prioritisation. Setting this out, it states that:

"Safety has also commanded significant resource. The new organisations and bodies cost money (around £60 million per year), while DHSC-sponsored reviews and inquiries into safety are estimated to have cost at least £100 million."

While this expenditure is not insignificant, it is dwarfed by the costs that are incurred because of the high levels of avoidable harm in the NHS. The cost of the NHS Clinical Negligence Scheme for Trusts alone in 2023/24 was £4,778 million.[7] In our initial response to the 10 Year Health Plan we set this out in more detail, highlighting the financial as well as a moral imperative to reducing avoidable harm in healthcare.[8]

We would also disagree that the costs of DHSC-sponsored reviews and inquiries into safety are evidence of 'over-prioritising safety'.

Investigations such as the Independent Medicines and Medical Devices Safety (IMMDS) Review and the inquiry into East Kent maternity and neonatal services were prompted by shocking cases of avoidable harm and patient deaths.[9] [10] These inquiries are a response to avoidable harm, providing insights into improvements needed, redress to harmed patients and an accountability framework to Parliament in the use of taxpayers' money. We would agree that there is a strong case to consider how these inquiries are carried out, particularly in relation to their timeframes and how and indeed whether their recommendations are subsequently implemented and evaluated.[11] [12]

However, to suggest these costs as evidence of a system that over-prioritises patient safety is simply not credible. These inquiries stem from failures in safety—they are the costs associated with a health system where avoidable harm persists. They do not represent an investment in improving patient safety, they are more focused on providing a better diagnosis of why harm occurs. We need to address the causal factors of avoidable harm, to alleviate pain and suffering as well as reducing the associated costs of remediating clinical services, clinical negligence and staff related costs. That should be our priority.

National Quality Board

"Recommendation 1: revamp, revitalise and significantly enhance the role of the National Quality Board."

Patient Safety Learning welcomes the review's central recommendation of reinvigorating and repurposing the existing NQB so that it is responsible for developing a comprehensive strategy to improve quality of care.

In our formal response to the review last year, we emphasised the need for improved coordination and joined-up working, particularly when it comes to safety issues. We also suggested that the review should consider taking an SMS approach to help ensure all elements of the system have a clear safety remit.[13] The issue of an SMS approach is something we will cover in further detail when responding in full to the Government's 10 Year Health Plan in the coming weeks.

We welcome the proposed role the revitalised NQB in:

- Building and maintaining a repository of recommendations from multiple sources.
- Operating a clearing-house function to co-ordinate and prioritise recommendations from national bodies (presumably it would not be appropriate to coordinate recommendations for action from investigations into avoidable harm in local NHS organisations).

The need for better coordination, management and evaluation of patient safety recommendations stemming from multiple sources is a pressing one. We have previously highlighted this issue in our report *Mind the implementation gap: The persistence of avoidable harm in healthcare*.[14] 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.

We note that 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 welcome. Minutes from the NQB's meetings in the last 12 months were only published on the day this review itself was released.

We look forward to seeing greater detail on this proposal in due course.

Health Services Safety Investigations Body

"Recommendation 3: continue the Health Services Safety Investigations Body's role as a centre of excellence for investigations and clarify the remit of any future investigations."

It is proposed that HSSIB will be transferred to the CQC, operating as a discrete unit within this. We welcome the review confirming that HSSIB will retain its role in carrying out patient safety investigations.

There were detailed discussions when this organisation was initially established as the Healthcare Safety Investigation Branch, and again when it was subsequently transformed into HSSIB, about the value and importance of its independence. In particular, the impact this would have on its credibility, and the need for patients and staff to be able to trust its focus on learning and not accountability or blame, to have confidence in its investigations

and recommendations. We will not seek to repeat these arguments here but would welcome further detail on how this will be protected and maintained while under the auspices of the CQC.

Education and training

"HSSIB should have a role advising and supporting best practice in local investigations. It should share learnings and retain its role in upskilling health organisations through its education function."

Patient Safety Learning welcomes the retention of this aspect of the organisation's role. HSSIB's valuable education programme currently includes specific training for NHS staff in implementing systems-based approaches to investigating patient safety incidents, recommended by the NHS Patient Safety Incident Response Framework (PSIRF).[15] The review also notes when referring to PSIRF that:

"The NHS has significantly enhanced its own capacity and capability to undertake reviews and investigations over the last 5 years with the establishment of the PSIRF and LFPSE."

We would emphasise that there is still a clear need and demand for PSIRF training and support. Although PSIRF has now been rolled out across NHS Trusts in England, we know from our extensive engagement with NHS organisations, specialist patient safety staff and healthcare leaders that this process is far from complete. Significant work is still needed to ensure that learning from high quality local investigations is translated into recommendations for improvement with action being taken to reduce harm and to share that knowledge across the healthcare system.

We hope to see a similar, if not increased, level of resource in this area as the transition to the CQC takes place.

Investigations

HSSIB is currently the main organisation that undertakes national patient safety investigations, other than the maternity investigations undertaken by the Maternity and Newborn Safety Investigations programme, hosted by the CQC. HSSIB investigations can help to capture broader systems issues and, in theory, share that learning across the system for patient safety improvement.

The review suggests future HSSIB investigations should be agreed in collaboration with the DHSC, via the NQB. As noted in the previous section, the NQB itself is also intended to act as a clearing-house for recommendations from these investigations.

With increased use of artificial intelligence (AI) and new technologies, we would expect that the review anticipates that insights from new sources such as this will help to inform topics agreed by HSSIB and the NQB for investigation. Specifically, the proposed new AI early warning system for safety concerns, which will be rolled out in maternity services later this year.[16]

However, we would suggest that a process is retained for insights to be provided by those on the frontline, both patients and staff. Currently everyone who uses or works in the

healthcare system, including patients, families, carers and healthcare staff, can raise issues that HSSIB may seek to investigate. We would like to see a commitment to retain this in some form under the new structure. If this is no longer available, we would look to see how systemic issues might be raised especially where they may be affected by management with more than one organisation.

Patient experience and the patient voice

"Recommendation 4: transfer the hosting arrangement of the Patient Safety Commissioner to the Medicines and Healthcare products Regulatory Agency (MHRA), and broader patient safety work to a new directorate for patient experience within NHS England, transferring to the new proposed structure within DHSC.

Recommendation 5: bring together the work of Local Healthwatch, and the engagement functions of integrated care boards (ICBs) and providers, to ensure patient and wider community input into the planning and design of services"

These two recommendations made by the review suggest a significant change to the NHS's approach to incorporating patient experiences and the patient voice.

Patient Safety Learning welcomes the proposal to create a new National Director of Patient Experience, which is also referenced in the 10 Year Health Plan. We look forward to seeing more detail of the scope and responsibilities of this role alongside a new Patient Experience Directorate.

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, and how this 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 roles are not mentioned in this review.

The review states that Local Healthwatch functions will be merged into existing involvement and engagement functions of ICBs. We would also expect to see proposals on how the new Patient Experience Directorate would 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—getting commitment to safer care by 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. We look forward to hearing more 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 Safety Commissioner

We have significant reservations about the role of Patient Safety Commissioner being transferred to the MHRA.

The impetus to create the role of Patient Safety Commissioner came from the IMMDS Review, which examined a truly shocking scale of avoidable harm caused by three medical interventions over several decades. In many cases patients and families affected by these interventions were ignored or dismissed.[17] The IMMDS review also identified significant shortcomings of the MHRA itself in relation to these cases. It proposed creating a new Commissioner to act as an independent and proactive public leader with a statutory responsibility to champion the value of listening to patients and promoting their perspectives in seeking improvements to patient safety.[18]

Patient Safety Learning does not believe that the proposal to transfer hosting of the Patient Safety Commissioner role to the MHRA is in keeping with the spirit of the findings and recommendations of the IMMDS Review. For example, it would be an issue if safety concerns are raised relating to the MHRA's own activities and the regulation of medicines and medical devices, as with the cases in the IMMDS Review. It seems unlikely that patients or the wider public would have confidence in an integrated leadership role's ability to 'speak truth to power' in such an arrangement without there being a significant change and confidence in MHRA's commitment, culture and performance.

We await more detail about the Patient Safety Commissioner role in the MHRA, the independence of this function and how these integrate with patient feedback from the Yellow Card scheme and complaints.

Culture

While we acknowledge that this wider issue is beyond the scope of this review, it does make a number of recommendations in relation to representing the staff voice that relate to this, including:

- Provider organisations should address the variable quality of their systems that support speaking up about concerns, driven by the work of Freedom to Speak Up Guardians.
- Responsibilities of the National Guardian for Freedom to Speak Up in the NHS and National Guardian's Office should be incorporated into providers, meaning the role of National Guardian will be removed.
- The CQC should be to assess whether every commissioner and provider has effective Freedom to Speak Up functions, with the right skills and training.

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.[19] 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 are 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 into becoming whistle-

blowers and then often treated with hostility when they are raising genuine concerns about patient safety. We discuss these in more detail in our new interview series, *Speaking up for patient safety*.[20] [21] [22]

There is little identification within this review of the significant changes that are needed to ensure that there is an open and fair culture with a focus on learning and improvement rather than blaming healthcare staff for systemic failings.

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. In our forthcoming response to the 10 Year Health Plan, we will set out in greater detail our views on culture in the NHS, which disappointingly was largely not touched upon in the Plan.

National approaches to learning and improvement

To conclude, there is one specific area we feel this review does not touch on but is a significant gap in the current patient safety landscape in England: the lack of structured systematic approaches to learning and solution development in the NHS.

NHS England and the role of the National Patient Safety Team was not considered as part of this review, although will undergo significant changes as its functions are merged into the DHSC.[23] This 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 as 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.

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Patient Safety Learning is register as a charity with the Charity Commission (Registration number 1180689).

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