Review of patient safety across the health and care landscape

Experts in health

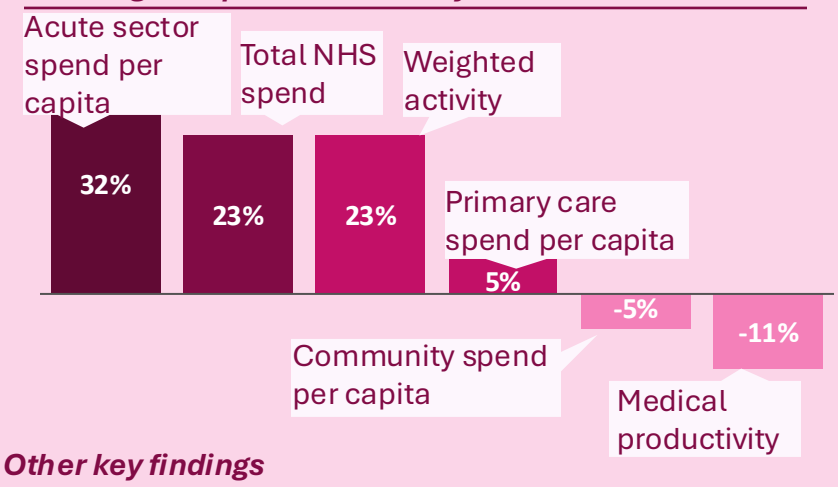
This review was commissioned by the Secretary of State for Health and Social care, following Dr. Penny Dash's earlier review of the Care Quality Commission (CQC) and responding to **concerns about a fragmented and overlapping care quality system.** It examines six key bodies: CQC, National Guardian's Office, HSSIB, Healthwatch England and the Local Healthwatch network, Patient Safety Commissioner, NHS Resolution, but the wider safety system includes 70+ bodies.

This causes duplication and confusion, impacting care quality: **780 deaths could have been avoided (in 2022), if the UK had matched the top decile of OECD countries for safety**. Opportunities for improving effectiveness of care are greater e.g. 7,000 deaths from poor care for diabetes alone.

Main findings

1. A ***disproportionate focus on safety*** has increased costs and resource use and decreased productivity without improving outcomes.

% change in spend and activity 2013/14-2023/24



Major gaps in quality relative to NICE standards are leading to gaps in diagnosis and treatment

CKD: 2.7 million people affected, contributing to 40,000-45,000 deaths per year. 18% remain undiagnosed and 32% of patients at stages 3-5 not optimally treated.

CVD: 26m+ people with untreated borderline high cholesterol 30% of adults have high bp, with most not receiving effective treatment

Dementia: 826,000 with dementia. 62,00 deaths / year. Over 35% undiagnosed. Only 6% of eligible patients receiving treatment.

Diabetes: Only 46% T1D patients received recommended care in 2023/24. Poor diabetes management causes c. 7,000 deaths / year

Cancer care: Only 54% cancers diagnoses at stage 1 and 2. Target of 96% treated within 31 days of decision not met in last 3 years

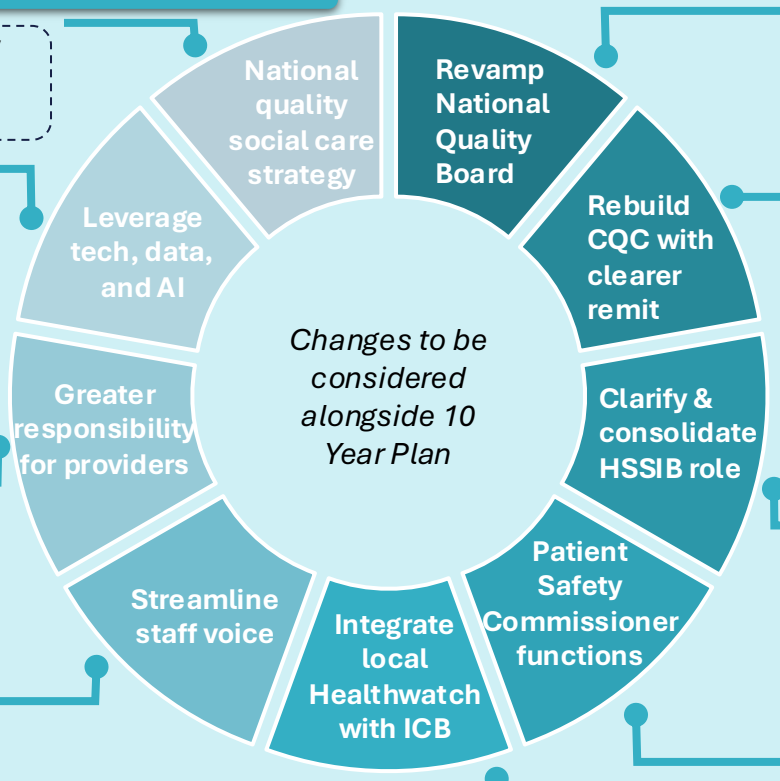
Other key findings

2. **Limited strategic thinking around improving quality of care and management:** last comprehensive strategy was in 2008 and should have led to a shift of care to the community, but the opposite has happened. More attention needed on governance and board effectiveness.
3. **Many organisations** carrying out reviews, and **confusing complaint system**: 1,400+ recommendations from 30 enquiries in England / Wales since 1995. 70+ feedback channels. 242,000 complaints in 23/24 vs 175,000 in 2013/14.
4. **User voice is fragmented**: as it outsourced to Healthwatch England and many other small organisations of varying quality. Few NHS boards have executive leads for patient experience
5. **Organisations expanding their scope and overlapping remits:** creating more complexity. HSSIB, CQC, and Patient Safety Commissioner expanded remits. National Guardian's office duplicates local Freedom to Speak Up Guardians
6. **Technology and data are underused:** despite the NHS being one of the most data-rich systems globally, insights and AI tools are not fully leveraged. And tech could be used better to ensure adherence to best practice and user experience.
7. **No national quality strategy for social care**: no national data collection of provider level clinical social care indicators

Core Problems

Cluttered landscape: c. 40 orgs. with formal quality of care role, many others giving advice	**Resource misallocation**: growing acute hospital staff, declining outcomes	**Poor data utilisation**: NHS not effectively using analytics to generate insights	**Weak governance**: variable effectiveness of boards and unclear accountability

Leading to 9 recommendations



Agree a set of metrics to assess quality of care and ensure appropriate governance structures

To be responsible for a comprehensive care quality strategy and prioritise recommendations

Use AI to identify poor-quality care and optimise intervention. Align with Sudlow Review to build on the federated data platform

Remain as principle independent regulator. Should restructure the single assessment framework

Emphasise leadership, governance and performance appraisals as poor management costs the NHS £5bn annually

HSSIB to continue as centre of excellence for investigations and support local investigations. Operate as independent branch in CQC.

Embed Freedom to Speak Up Guardians in providers and commissioners. Supported by CQC

Safety and feedback of medicines and devices hosted by MHRA, with wider patient safety work to move to new DHSC directorate

And strategic functions of Healthwatch England should be transferred to the new directorate for patient experience at DHSC

Conclusion

Fundamental quality issues persist despite massive investment in safety infrastructure. Yet, it is entirely feasible to see a step change improvement in care outcomes if the recommendations for a coordinated strategy are implemented.

Source: Review of patient safety across the health and care landscape – Independent Report