NHS patient safety strategy – progress so far

Emerging evidence shows that the NHS patient safety strategy (https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/) is making progress towards the impact we anticipated in 2019: saving an additional 1,000 lives and £100 million per year. Latest figures from June 2023 indicate we are halfway to achieving that aim.

Much progress is being made across the strategy's main programmes of work which you can read about on the dedicated webpages for Learn from patient safety events (LFPSE) service (https://www.england.nhs.uk/patient-safety/learn-from-patient-safety-events-service/primary-care-information/), Patient safety incident response framework (https://www.england.nhs.uk/patient-safety/incident-response-framework/), Patient safety specialists (https://www.england.nhs.uk/patient-safety/patient-safety-specialists/), Framework for involving patients in patient safety (https://www.england.nhs.uk/patient-safety/framework-for-involving-patients-in-patient-safety/), Patient safety syllabus (https://www.hee.nhs.uk/our-work/patient-safety), how we learn from patient safety events (https://www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-patient-safety-events/) and the introduction of National Patient Safety Alerts (https://www.england.nhs.uk/patient-safety/national-patient-safety-alerting-committee/).

Highlights of the impact of the NHS patient safety strategy include:

- The National Patient Safety team, supported by staff across the NHS identifying and recording patient safety incidents, continues to save an estimated 160 lives per year through mitigation of risk (https://www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-patient-safety-events/). This is also estimated to reduce disability due to severe harm incidents by around 480 cases per year and to save £13.5 million in additional treatment costs.

View our National Patient Safety Alerts (https://www.england.nhs.uk/patient-safety/patient-safety-alerts/) and Review and response case studies (https://www.england.nhs.uk/patient-safety/using-patient-safety-events-data-to-keep-patients-safe/how-we-acted-on-patient-safety-issues-you-recorded/) for examples of this work.

- Since the strategy was launched, an estimated 291 fewer cases of cerebral palsy have occurred since September 2019 due to the administration of magnesium sulphate during pre-term labour as part of the PReCePT programme, supported by the Patient Safety Collaboratives. This has saved up to £291 million in lifetime care costs, assuming £1 million per case.

Read our PReCePT – using magnesium sulphate to reduce cerebral palsy in pre-term babies case study (https://www.england.nhs.uk/long-read/precept-using-magnesium-sulphate-to-reduce-cerebral-palsy-in-pre-term-babies/)

- Work supported by the Maternity and Neonatal Safety Improvement Programme to ensure optimal cord management during labour has saved up to 465 lives since 2020.

Read our Saving pre-term babies lives through optimal cord management case study (https://www.england.nhs.uk/long-read/saving-pre-term-babies-lives-through-optimal-cord-management/)

- We estimate 414 fewer deaths and 2,569 fewer cases of moderate harm due to long term opioids following the work of our Medication Safety Improvement Programme since November 2021.

Read our Reducing long-term opioid use case study (https://www.england.nhs.uk/long-read/reducing-long-term-opioid-use/)

- The Medication Safety Improvement programme has also led to:
    - 420 fewer admissions for major bleeds per year from anticoagulants and non-steroidal anti-inflammatory drugs (NSAIDs)
    - 1,979 fewer cases of drug induced acute kidney injury
    - 104 fewer asthma/COPD admissions due to sub-optimal inhaler prescribing
    - 1,000 fewer patients at risk of methotrexate overdose.
    - 16,920 hospital readmissions avoided by Discharge Medicines Service

We estimate this has released over £7 million in admissions costs.

- Early adopters of the Patient Safety Incident Response Framework (PSIRF) (https://www.england.nhs.uk/patient-safety/incident-response-framework/) are reporting improved safety cultures, identification of more effective risk