Quality versus safety in healthcare – a national debate for patient care

Woodier N, Back J, Owens D, Vosper H & Bowie P

Health Services Safety Investigations Body, UK

SUMMARY

A 2025 review of the patient safety landscape in England described that the National Health Service's focus on safety has been at the detriment of other aspects of quality of care, such as effectiveness. Concerns have been raised that the review will lead to de-prioritisation of patient safety due to a fundamental misunderstanding of safety science. This paper provides an overview of an exploratory study of 1) perceptions around quality and safety in healthcare, and 2) evidence of trade-offs seen in national safety investigations. The paper concludes that safety should be considered as the foundation for quality, rather than as a dimension of quality. It recommends 1) a fundamental rethink about how the NHS views and prioritises patient safety, and 2) the need for healthcare to employ evidence-based safety and risk management principles.

KEYWORDS

Safety, quality, healthcare

Introduction

The organisation of the National Health Service (NHS) in England is undergoing significant change, with an increasing focus on 'quality' (Department of Health and Social Care, 2025a). Alongside the plans for NHS reorganisation, the Department of Health and Social Care (2025b) published a review of the patient safety landscape across the NHS in England. The review described that there had been a 'shift' towards safety with detriment to other dimensions of quality. In response, it recommended that the NHS focuses on performance, 'value' and prioritises a 'balance across all dimensions of quality'.

Several definitions of quality in healthcare exist, all of which include multiple dimensions. In the Department of Health and Social Care's (2025b) review, quality was described to typically include safety, effectiveness, user (patient) experience, accessibility, equity and efficiency (see figure 1).

The response to the Department of Health and Social Care's (2025b) review of the patient safety landscape has been mixed. Various public bodies, academics and patient groups have aired concerns about its logic and the 'de-prioritisation' of patient safety (e.g. Macrae, 2025; Woodward, 2025). Contemporary safety science theory also suggests that the balance being sought across the dimensions of quality is unlikely to be achieved due to the interplay between competing organisational priorities that will ultimately lead to drift and unsafe situations (Rasmussen, 1997). It is well documented that, when resources are limited, reduced thoroughness is inevitable and will impact on safety – the efficiency-thoroughness trade-off (ETTO) principle (Hollnagel, 2009).

The review of the patient safety landscape has prompted several unanswered questions for the NHS – What are safety and quality? How do safety and quality interrelate? Can the NHS have balance across quality dimensions including safety? Is there evidence that a focus on patient safety has impacted on other dimensions of quality? Answering these questions is essential if healthcare is to

develop a future operating model rooted in safety science that meets the needs of the population while ensuring patient safety is not compromised further.

To start to answer the above questions, we sought the insights of safety professionals and, combined with a review of the outputs of national safety investigations, developed narrative answers to prompt consideration and understanding of different perspectives around quality and safety in the NHS.

Figure. 1: Dimensions of quality adapted from Department of Health and Social Care (2025b)

Methods

Study design and data collection

Permission to conduct the project was obtained through the Health Services Safety Investigations Body (HSSIB).We used qualitative means to gather data and inform the narrative answers to the questions above. We undertook a round-table discussion with safety professionals and conducted a thematic review of national safety investigation reports.

Volunteer participants for the discussion were recruited from the HSSIB workforce. The workforce comprises safety investigators and analysts; academics and researchers; and educators and governance managers. The workforce has a breadth of experience and insight into healthcare and other safety-critical industries including rail, nuclear and aviation. Participants were invited to a semi-structured discussion of the questions which was recorded and transcribed. Individual interviews were conducted where staff were unable to attend the discussion.

The national safety investigation reports were those published by HSSIB and its predecessor (the Healthcare Safety Investigation Branch, HSIB). All HSSIB/HSIB reports published since 2017 (when HSIB was launched) were initially included.

Data analysis

Analysis of the participant discussion used a typical thematic approach (Braun and Clarke, 2021) and themes were agreed among the study authors. The review of investigation reports used a template analysis approach to identify evidence of trade-offs. We defined that a trade-off had

occurred where reports described how a focus on performance against one dimension of quality (e.g. patient experience) had negatively impacted on another dimension (e.g. safety).

To identify trade-offs, three approaches were used: 1) structured keyword searches of reports using NVivo 15; 2) reading of reports identified as containing evidence of trade-offs as determined by participants in the discussion; and 3) structured searches of concepts and ideas using Microsoft 365 Copilot. Where searches identified trade-offs, these were themed using NVivo 15 with examples.

Results

Twenty-three participants engaged with the discussion. Participants were safety investigators (n=9) and safety analysts (n=4); academics, researchers and educators (n=4); and from managerial roles (n=6). Participants had different operational and research backgrounds including healthcare, law, aviation, rail, military, human factors, psychology, risk, quality improvement and governance. The key themes to emerge are shown in table 1 with representative quotes.

Table 1. Themes emerging from the participant discussion

Theme	Description	Quote
Safety and quality are oversimplified in healthcare	Concepts are not clearly defined, agreed or understood. Oversimplification leads to misunderstanding about how to address issues. Concepts may also be seen as adversarial.	"[Healthcare's] way of thinking about and doing safety are antithetical to complexity and safety science".
Safety is the foundation of quality	Safety is often considered as a dimension of quality. However, it may be better considered as the foundation on which quality is built. High-quality care cannot be built on harm.	"Quality can be built on once you have a safe system… you need a safe bridge before you have a nice looking bridge".
Seeking a balance will degrade safety	A focus on value and balance across the dimensions of quality may place more worth on one over another. If safety is seen is a dimension of quality it will face trade-offs.	"The way we see safety and quality promotes these trade-offs including teams vying for the same limited resources and needing to show their value".

One hundred and eighteen safety investigation reports published by HSSIB/HSIB since 2017 were reviewed. 43 reports described clear evidence of a trade-off. The majority of these related to a negative impact on patient safety because of the prioritisation of other dimensions of quality. Reports described various factors contributing to trade-offs at local, regional and national levels of the healthcare system. Examples of the trade-offs included:

- **Safety and efficiency** (HSIB, 2022a): a patient developed a blood clot after birth of her baby. She had not received preventative medications. Competing demands, exacerbated by distractions, mean healthcare professionals are constantly having to balance risk and safety and are trading off the thoroughness of risk assessments to improve efficiency.
- **Safety and patient experience** (HSSIB, 2025): online consultation tools have been introduced into general practice, in part to support improvements in patient experience. While tools have improved experience for some, the design and configuration of a tool may mean it is not always able to safely deliver the task it is being used for, nor address the needs of its users.
- **Safety and accessibility** (HSIB, 2022b): decision making in the identification of pulmonary embolism in emergency departments may be impaired by a focus on targets

(national operating standard). Staff described having to make rapid decisions about patients who had been in their EDs for almost 4 hours. Staff sometimes felt pressurised to meet the standard.

No evidence of patient safety being prioritised over other dimensions of quality were identified amongst the trade-offs. Several reports described the concept of 'As Low As Reasonably Practicable' (ALARP) and those reports recognised that assessment of risk and costs is required to understand whether a risk has been reduced as far as is reasonably practicable.

Discussion

Using the participant discussion and insights into trade-offs described in the investigation reports, we aimed to answer the questions in the background. The following subsections provide a narrative response to the questions with reflections drawing evidence from the safety science literature.

What is safety and quality, and how do they interrelate?

Discussions highlighted differences in individual interpretation of the concepts of safety and quality. There were differences in how participants from healthcare backgrounds viewed the concepts when compared to participants from other safety-critical industries. It was suggested that healthcare has an oversimplified view of both safety and quality.

Regarding the concept of safety, participants reflected that safety is defined in relation to the avoidance of harm; this aligns with the World Health Organisation's (2019) definition. However, participants agreed that this superficial definition fails to recognise the nuances of different types of harm and the complexity of how harm occurs in contemporary healthcare systems. These systems represent a diverse range of complex, sociotechnical and adaptive interactions where outcomes are emergent. Healthcare's view of safety and the models it has traditionally applied were described as "antithetical" to the realities of modern healthcare and safety science.

Participants described safety as an "approach" which applies safety-science and systems-thinking principles to the study and management of situational risks that are recurrent or newly identified. It is also an approach that recognises that complete avoidance of harm in safety-critical systems is unlikely and so rather seeks to reduce risks to ALARP. Aligned with the pillars of safety management (HSSIB, 2023), the safety approach involves 1) hazard/risk identification and control; 2) assurance of safety controls and development of system resilience to anticipate, monitor and respond to changes that place safety at risk; 3) promotion of proactive and positive safety cultures that engage patients and staff in safety activities; and 4) development of organisational frameworks for safety with clear roles and responsibilities for all staff.

In contrast to safety, participants found it easier to define quality in healthcare in relation to specific dimensions, such as experience, efficiency and effectiveness. Various models were discussed, including that published by the Institute of Medicine (2001); participants questioned the evidence-base behind this often quoted model and whether it is representative of modern healthcare systems.

Participants described views that the quality approach aligns with the examination and measurement of performance against key indicators, reducing variability and assuring compliance to standards. Improving reliability of care processes was discussed, but participants were eager to challenge a 'stubborn myth' that increasing reliability of care processes leads to safety when in reality system components can function as intended (reliability) but the complex interactions between components can lead to unsafe systems (Catchpole et al., 2020; Leveson, 2012).

Participants also considered that indicators of quality can be clearly defined and can have targets set against them – for example, the NHS England's (2025) urgent and emergency care plan for 2025/26

sets a minimum timeliness target that 78% of patients who attend an emergency department are admitted, transferred or discharged within 4 hours. In contrast, safety could not be reduced to a single measure, indicator or target; no measure to understand safety of the above emergency department timeliness target has been developed.

The role of incident reporting as a metric for safety was debated and, while the importance of identifying and responding to incidents was agreed, its value was challenged. Incident reporting data is notoriously limited and its use as a metric of safety is conceptually flawed and oversimplistic (Shojania, 2008). Instead, for organisations to describe safety of their systems, participants suggested the need to "paint" a picture or describe a "narrative" about their safety using multiple forms of qualitative and quantitative information, and leading and lagging metrics. The 'measuring and monitoring of safety' conceptual framework was suggested as a useful guide (Vincent et al., 2013); the authors of that framework viewed quality as addressing the intended results of healthcare systems, and safety as concerned with the ways in which a system can fail to function.

The above discussions led participants to agree that safety and quality are both important concepts in healthcare but that they are distinctly different; quality management (International Organization for Standardization, 2015) is therefore different to safety management (HSSIB, 2025b). Those differences relate to theoretical underpinnings and purpose. Because of the differences, participants disagreed with the representation of safety as a dimension of quality.

Can the NHS have balance across quality dimensions?

When commencing this project, the authors' mental model of quality in healthcare included safety as a dimension; we call this the 'dimensional' model (figure 1). Our dimensional mindset had been informed by publications describing that quality has several dimensions including safety (e.g. Institute of Medicine, 2001). Within the dimensional model, the trade-offs identified in the review of safety investigation reports demonstrate that a balance across the dimensions of quality is challenging and unlikely. Trade-offs were seen at individual, organisation and wider system levels and commonly involved the safety dimension (often considered in relation to thoroughness) being negatively influenced by efforts to improve efficiency or timeliness (see Hollnagel, 2009).

Using the dimensional model, participants debated whether the different dimensions of quality are weighted equally. The debate considered that, in reality, some dimensions will be prioritised over others depending on the lens through which quality is being considered, and one or more dimensions will be de-prioritised when there are limited resources. Participants were concerned about the absence of a "bottom line" for safety in the dimensional model, beyond which safety must not be de-prioritised further. Without this line there is the potential for systems to "drift" into danger (Rasmussen, 1997). Drift has been clearly described in non-healthcare industries and has been demonstrated as contributory to some of the most catastrophic events in the safety literature (e.g. Vaughan, 1996).

In contrast to the dimensional model, we concluded from the participant discussion that safety is not a dimension of quality. Rather it is as a foundational concept on which quality is built; we call this the 'foundational' model (see figure 2). Within the foundational model, participants described safety as being a bottom line or "hard deck" below which organisations must not pass, but that is also constantly evolving . This is conceptually different to the trading off between different dimensions of quality (including safety) and instead views safety as a non-negotiable entity.

Participants described the foundational model as a way to ground discussions around patient safety. However, they were cautious to ensure that the bottom line is not interpreted or oversimplified as a target or just a fixed line. Rather, the foundations need to be considered in line with evidence-based safety theory, and constantly reviewed and developed. This includes recognition that healthcare is a

safety-critical industry with complex systems within which staff make risk-based and potentially harmful decisions everyday; incidents and harm are inevitable (see Perrow, 1999). Safety foundations therefore need to consider how to develop strong barriers to known hazards and ensure systems and those working in them are able to monitor for, respond to, anticipate, and learn from situational risks (Hollnagel et al., 2015).

Participants further reflected that, when considering safety, the NHS has limited understanding of risk and has paid limited attention to risk appetite. Risk appetite is the amount of risk an organisation is willing to accept to achieve its objectives (NHS England, 2024). Common statements that 'patient safety is our top priority' were challenged as contradictory to the way quality is viewed in the NHS and do not align with the intentions of the review of the patient safety landscape (Department of Health and Social Care, 2025b). Participants argued that, if patient safety is truly the top priority, then this fits with the foundational model described above. Participants also returned to the concept of ALARP when discussing a risk threshold. ALARP is a fundamental concept for risk management but is not familiar at patient safety policy levels in healthcare. Policy makers in healthcare may want to believe that risk can be eliminated – as exemplified by the continuing focus on never events in the NHS (HSIB, 2021) – but in reality, it is not possible or 'practicable' to eliminate or reduce some risks further.

Returning to the original question for this subsection, within the foundational model of safety, the question about balance across the dimensions of quality becomes mute; safety is not a dimension of quality. Instead, the question should be 'how can the dimensions of quality be balanced appropriately without degrading the safety foundation'?

Is there evidence that a focus on patient safety has impacted on other dimensions of quality?

The Department of Health and Social Care's (2025b) review of the patient safety landscape stated that it 'appears that the focus on safety has been at the expense of other aspects of quality of care' and that, despite the resource allocated there has been 'limited progress improving safety'. In our review of investigatory reports from the past 8 years we did not identify examples of where prioritisation of safety had negatively impacted on other dimensions of quality; repeated examples to the contrary were identified. We recognise that this is absence of evidence and unsurprising considering the reports are those of a patient safety organisation. However, while acknowledging our bias towards safety, participants questioned whether the review's conclusions were themselves biased by a quality-orientated lens.

Regarding the review's finding of 'limited progress improving safety', this has come under challenge by participants and others outside of our study. Woodward (2025) challenged that it would be 'wrong to say improvements have been limited' and highlighted how there had been significant improvements in knowledge, expertise and understanding of what we now call patient safety. Participants argued that the NHS's patient safety culture has progressed significantly with evidence of greater focus on supporting those affected after safety events and a more positive and proactive approach to safety. When compared with other industries, participants also argued that the NHS has come from a different place and is at a different point in its safety maturity; those industries took many years to reach their current levels of safety. The NHS needs more time to progress towards those safety levels but with recognition, again, that the complex adaptive nature of healthcare systems mean those levels are unlikely to be able to be reached.

Limitations

The above answers to the questions and associated reflections are based on the study's findings through the described methods. We recognise potential limitations of this work, not least that the

majority of participants have safety backgrounds and are advocates for patient safety. We appreciate that preconceptions and past experiences will have influenced the narrative.

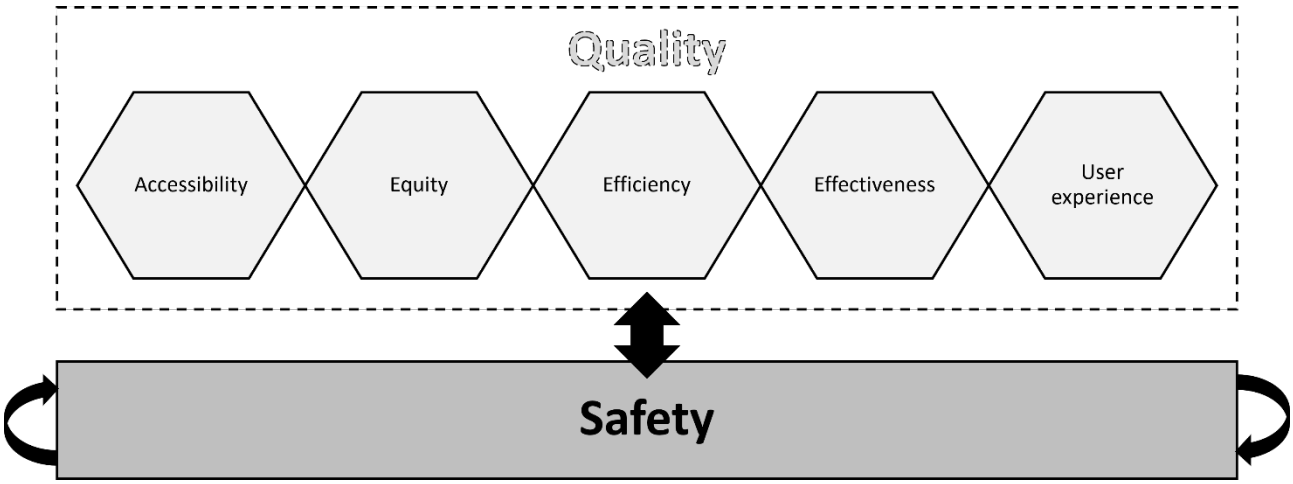

Figure 2: Safety as the foundation for quality with demonstration of 1) the interaction between safety and quality, and 2) that safety is under continuous review and development

Conclusion and recommendations

Patient safety must always be a priority for the NHS and the reflections in this paper fully support this. However, by the nature of healthcare, some patients will come to harm through the very processes that are meant to help them. This is the important reality to recognise. That reality also demonstrates why the NHS needs to understand what safety is and how best to apply appropriate theory and methods to mitigate risks to patients.

The NHS is undergoing a period of significant change. In response to national plans, various organisations, academics and patient groups have aired concerns about the prioritisation of quality at the expense of safety. These concerns are valid and exist at a time when safety is already of concern with staff finding it increasingly challenging to keep patients safe. These concerns must be heard and future plans must ensure that patient safety is a non-negotiable priority for the NHS.

To support future discussions about safety and quality in healthcare, we propose that safety is considered as the foundation for quality, rather than as a dimension of quality. That foundation is continually being managed, reviewed and developed. This is more than just semantics because the concepts have different theoretical underpinnings and goals. We also recommend that the NHS considers how best to apply contemporary safety and risk management principles to patient safety; in support, HSSIB (2023) has previously recommended formation of a safety management system co-ordination group and this is making positive progress.

Returning to the title of this paper. By viewing safety as the foundation for quality, there is no ‘safety versus quality’. This view can support the creation of opportunities for collaboration and integration between safety and quality with a focus on improving overall patient safety and the quality of care patients receive.

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