SPS Medication Safety Update July 2025

Recent critical patient safety alerts, reports, and publications

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The first stop for professional medicines advice

30/07/2025

Patient Safety Alerts

Shortage of bumetanide 1mg tablets

Issued: 3/7/2025

Deadline: 11/7/2025

Bumetanide 1mg tablets are in limited supply until late July 2025

The supply disruption is caused by a combination of manufacturing issues and a resulting increase in demand to other suppliers.

Bumetanide 1mg/5ml oral solution and bumetanide 5mg tablets remain available, however cannot support any increase in demand.

Furosemide 20mg and 40mg tablets remain available and can support increased demand.

Actions:

- Do not initiate new patients on bumetanide 1mg tablets until the supply issue has resolved.
- Identify all patients currently prescribed bumetanide 1mg tablets; review to determine if this is still the most suitable therapy and if patients have sufficient stock to last until the resupply date.
- Patients with insufficient supplies should be considered for furosemide tablets ensuring that the patient is not intolerant to any of the excipients, is counselled on the appropriate dose to take, additional weight monitoring requirements and to report any side effects and loss of treatment response
- Patients who fit the criteria should be prioritised for remaining supplies of bumetanide 1mg tablets
- Prescribers should immediately refer patients to a specialist for advice on alternative treatments if above options are not suitable.

Patient Safety Alerts

Potential contamination of non-sterile alcohol-free skin cleansing wipes with Burkholderia spp: measures to reduce patient risk

Issued: 26/06/2025

Deadline: 29/08/2025

UKHSA is investigating an outbreak of Burkholderia stabilis involving individuals across the UK, linked to wipes. Following testing, Burkholderia spp (full identification pending) has been recovered from several non-sterile alcohol-free skin cleansing wipes, including those used for wound care and included in first aid kits.

Actions:

- Ensure local guidance and practice reflects National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England (ePIC3).
- Ensure patients in the community with intravascular devices are aware to only use wipes if instructed by their clinical teams.
- Community healthcare providers should advise patients to only use wipes marked as sterile on any broken skin
- Submit any isolate from a new infection with Burholderia cepacia complex.

Patient Safety Alerts

Shortage of Antimicrobial Agents Used in Tuberculosis (TB) Treatment

Issued: 29/07/2025

Deadline: 15/08/2025

The following antimicrobial medicines used to treat tuberculosis (TB) will be intermittently available until at least the end of 2025:

- Rifampicin 150mg and 300mg capsules
- Rifampicin 600mg IV solution for infusion
- Rifampicin 100mg/5ml oral suspension
- Rifinah® 300 tablets (rifampicin 300mg / isoniazid 150mg)
- Rifater® tablets (rifampicin 120mg / isoniazid 50mg/ pyrazinamide 300mg)
- Voractiv® tablets (rifampicin 150mg/ isoniazid 75mg / pyrazinamide 400mg / ethambutol 275mg)
- Pyrazinamide 500mg tablets
- Ethambutol tablets, Isoniazid tablets, and Rifinah® 150 tablets (rifampicin 150 mg / isoniazid 100 mg) and Mycobutin® (rifabutin) 150mg capsules remain available but cannot support a full increase in demand.

Actions: (to remain in place until supply issues have resolved):

- Hospital Procurement Teams in NHS Trusts should review stock holdings of all anti -TB agents and proactively work to urgently access stock of licensed or unlicensed supplies, where available.
- Patients with TB who fit the criteria (see Note A) should be prioritised for remaining supplies of antiTB oral medicines.
- Primary care clinicians should not prescribe rifampicin until the shortage is resolved.
- Appropriate prescribers should amend prescriptions when the usual/preferred product is unavailable to avoid delays or interruptions in treatment.
- Appropriate prescribers should limit prescriptions of affected oral anti-TB medicines to a maximum of one month’s supply to conserve stock.
- Consult local antimicrobial specialists to identify appropriate alternatives to rifampicin when managing indications other than tuberculosis or nontuberculous mycobacterial disease (NTM)
- In urgent cases, consult the SPS RPPS teams to facilitate mutual aid between NHS provider trusts
- Ensure patients are informed about changes to their usual or expected medication.
- Ensure multi-language patient-facing communications are provided where appropriate, ensuring patients are informed of any medication changes.

Recent regulator and statutory body activity

MHRA Drug Safety Updates:

Abrysvo▼ (Pfizer RSV vaccine) and Arexvy▼ (GSK RSV vaccine): be alert to a small risk of Guillain-Barré syndrome following vaccination in older adults

There is a small increase in the risk of Guillain-Barré syndrome following vaccination with Abrysvo (Pfizer respiratory syncytial virus (RSV) vaccine) and Arexvy (GSK RSV vaccine) in adults aged 60 years and older. Healthcare professionals should advise all recipients of Abrysvo and Arexvy that they should be alert to signs and symptoms of Guillain-Barré syndrome and, if they occur, to seek immediate medical attention as it requires urgent treatment in hospital.

UKHSA issues warning over botulism

UKHSA warns public to be alert to botulism following adverse reactions to cosmetic procedures involving botulinum toxin.

Recent regulator and statutory body activity

Class 2 Medicines Recall: Depo-Medrone 80 mg in 2 mL, Maxearn Limited EL(25)A/29

A batch of Depo-Medrone has been released to the market with an error. The vial over label incorrectly states that the total vial content is 40 mg in 1 mL, when the correct total vial content is 80mg in 2 mL.

Class 2 Medicines Recall: Zaditen 0.25 mg/ml, eye drops, solution, Laboratoires Théa EL(25)A/34

Laboratoires Théa trading as Thea Pharmaceuticals Limited have notified the MHRA of an out of specification event related to environmental monitoring during manufacturing, which may increase the risk of microbial contamination of the medicinal product.

Class 2 Medicines Recall: Flutiform 250 micrograms / 10 micrograms per actuation pressurised inhalation, suspension , CD Pharma Ltd, EL(25)A/35

CD Pharma Ltd have notified the MHRA of an error on the outer carton of the product for the batches listed in this notification. While the total active content statement is correct, the delivered dose content statement is incorrect. The other details on the carton are correct.

Class 3 Medicines Recall: Kimmtrak 200 micrograms/mL concentrate for solution for infusion, Immunocore Limited, EL(25)A/28

Immunocore Limited is recalling some specific batches as a precautionary measure. The recall is due to a decrease in potency identified during stability testing.

Recent regulator and statutory body activity

Class 3 Medicines Recall: Omeprazole 20 mg/15 ml Oral Solution, Glenmark Pharmaceuticals Europe Ltd, EL(25)A/30

Glenmark Pharmaceuticals Europe Ltd is recalling a specific batch of Omeprazole Oral Solution as a precautionary measure due to an investigation following a customer complaint indicating precipitation and discoloration of the product in the bottles.

Class 3 Medicines Recall: Tamoxifen 20mg Film-Coated Tablets, Wockhardt UK Ltd, EL(25)A/31

Wockhardt UK Limited is recalling a batch as a precautionary measure following the identification of a dissolution failure during stability testing.

Class 4 Medicines Defect Notification: Erythromycin Stearate BP 250mg Tablets, Amdipharm UK Ltd, EL(25)A/32

Amdipharm UK Ltd has informed MHRA that the Patient information leaflet (PIL) in the cartons for the batch listed in this notification includes a superseded PIL.

Class 4 Medicines Defect Notification: Simvastatin 10mg Tablet, Crescent Pharma Ltd, EL(25)A/33

Crescent Pharma Limited has informed the MHRA of an error with the European Article Number (EAN) barcode on the cartons of a batch of simvastatin 10 mg Tablets distributed by Alliance Healthcare UK.

Pharmacovigilance Risk Assessment Committee (PRAC)

Meeting held on 7-10 July 2025

Ixchiq: temporary restriction on vaccinating people 65 years and older to be lifted

EMA's safety committee has completed its review of Ixchiq (a live attenuated chikungunya vaccine), following reports of serious side effects. The previous temporary restriction on vaccinating people aged 65 years and above, which was put in place during the review, will now be lifted.

However, the Committee concluded that, for people of all ages, the vaccine should only be given when there is a significant risk of chikungunya infection and after a careful consideration of the benefits and risks.

Review of risk of encephalitis with varicella vaccines concluded

PRAC has concluded its review of the known risk of encephalitis (inflammation of the brain) with the varicella (chickenpox) vaccines Varilrix and Varivax. The review was triggered by a case of encephalitis with fatal outcome after vaccination with Varilrix.

After carefully evaluating the available evidence from clinical trials, the scientific literature and post-marketing exposure, the committee has recommended an update to the product information of Varilrix and Varivax to further describe the severity of the risk of encephalitis. The two vaccines remain contraindicated in immunocompromised people and no additional risk minimisation measures are required.

Pharmacovigilance Risk Assessment Committee (PRAC)

Meeting held on 7-10 July 2025

PRAC assessing new data on potential risk of neurodevelopmental disorders in children born to men treated with valproate

Committee will review results of a recent study which does not replicate previous findings

In January 2024, the assessment of the findings of a post authorisation safety study (PASS) carried out by companies that market valproate, which used data from multiple registry databases in Denmark, Norway and Sweden, together with other available information, led the PRAC to recommend precautionary measures for the treatment of male patients with valproate medicines. At that time, while the committee acknowledged that the PASS data had limitations, PRAC concluded that NDD are a potential risk in children born to men treated with valproate during the three months before conception, and therefore information to patients and health care professionals were warranted.

PRAC is assessing new data from a recent study which used multiple databases in Denmark to investigate the potential risk of neurodevelopmental disorders (NDD) in children born to men treated with valproate, levetiracetam or lamotrigine before conception.

The aim of this new study using Danish data sources was to replicate the results from the PASS. However, results from this new study did not suggest an association between valproate use by the father and an increased risk of NDD in the child.

PRAC has initiated a signal procedure to understand the difference in the findings across the studies and requested further information and analysis from the marketing authorisation holders for valproate.

Pharmacovigilance Risk Assessment Committee (PRAC)

Meeting held on 7-10 July 2025

New safety information for healthcare professionals

Clozapine: Revised recommendations for routine blood count monitoring

PRAC has endorsed a DHPC informing about revised recommendations for the monitoring of the blood count to minimise the risk of severe neutropenia and agranulocytosis with clozapine. Clozapine is known to increase the risk for neutropenia and agranulocytosis, and regular blood count monitoring is in place to minimise this risk. New evidence from the scientific literature suggests that, although clozapine-induced neutropenia can occur at any time during treatment, it is predominantly observed during the first year, with the incidence peaking in the first 18 weeks of treatment. After this the incidence decreases becoming progressively lower after two years of treatment in patients without previous episode of neutropenia.

Therefore**,** PRAC recommended less frequent blood count monitoring. For example, in patients without neutropenia, the frequency of monitoring is reduced to every 12 weeks after one year, and to once a year after two years of treatment. Furthermore, monitoring is now recommended to be based solely on the count of absolute neutrophil count (ANC), a measure of the number of neutrophils. This aligns with current evidence that ANC is a more specific and clinically relevant marker for assessing the risk of neutropenia. Therefore, the requirement for monitoring white blood cell counts has been removed.

PJ - Clozapine: is it time to relax blood monitoring rules?

Direct HCP communication

Direct Healthcare Professional Communication: Introduction of new 10 ml CONNECT syringe glass barrel to the Aurum Range of Prefilled Syringes

The new syringe glass barrel has a wider internal channel and a fixed Luer lock adapter. Both barrel types will be on the market until March 2028, so it is essential that stakeholders can identify which barrels they have in stock, and which needle-free connectors they should use

SPC changes or Manufacturer RMM

Revised SPC: Rifater 50mg/120mg/300mg (isoniazid, rifampicin, pyrazinamide) Tablets

Severe cutaneous adverse reactions (SCARs) such as Stevens-Johnson syndrome and toxic epidermal necrolysis have been reported with Rifater. Patients should be informed about signs & symptoms and monitored closely. Treatment discontinuation should be considered if SCARs occur.

Revised SPC: Zavicefta (avibactam, ceftazidime) 2 g/0.5g powder for concentrate for solution for infusion

SPC updated to include a warning related to severe cutaneous adverse reactions, and to include acute generalized exanthematous pustulosis as an adverse drug reaction with unknown frequency.

Revised SPC: Eklira Genuair (aclidinium bromide) 322 micrograms inhalation powder

SPC updated to note that cardiac arrhythmias have been seen after the administration; it should therefore be used with caution in people with cardiac arrhythmias, a history of cardiac arrhythmias or with risk factors for cardiac arrhythmias.

SPC changes or Manufacturer RMM

Revised SPC: Truqap (capivasertib) 160mg film-coated tablets

SPC updated to include information and cautions about hyperglycaemia, including the need for blood glucose and HbA1c monitoring in patients treated with Truqap. Diabetic ketoacidosis added as an adverse effect, frequency 'uncommon'.

Revised SPC: Octasa (mesalazine) – all preparations

Idiopathic intracranial hypertension (IIH) has been reported in patients receiving mesalazine. Patients should be warned for signs and symptoms including severe or recurrent headache, visual disturbances or tinnitus, and mesalazine should be discontinued if IIH occurs.

Drug shortages and discontinuations

Recent medicine shortages and discontinuations are available via: the SPS Medicines Supply Tool (registration required to access)

Medicine Supply Notification: Salbutamol 100micrograms/dose breath actuated inhalers CFC free

Salamol Easi-Breathe® is out of stock until mid-September 2025; following resupply, stock will be limited until December 2025. Airomir® has been discontinued. Salamol® CFC free pressurised MDI and Easyhaler® dry powder inhaler remain available and can support increased demand.

Medicine Supply Notification: Amiodarone 200mg tablets

Amiodarone 200mg tablets are out of stock until early August 2025. Amiodarone 100mg tablets remain available and can support a limited increase in demand. Alternative antiarrhythmics agents remain available.

Medicine Supply Notification: Diclofenac (Voltarol® Ophtha) 0.1% eye drops 0.3ml unit dose preservative free

These eye drops are out of stock until early October 2025. Ketorolac, bromfenac and nepafenac eye drops remain available and can support increased demand (all contain preservative benzalkonium chloride). Preservative free corticosteroid eye drops remain available.

Drug shortages and discontinuations

Recent medicine shortages and discontinuations are available via: the SPS Medicines Supply Tool (registration required to access)

Medicine Supply Notification: Betamethasone 500microgram soluble tablets sugar free

These are out of stock until late July 2025, when a limited resupply is expected; full resupply is anticipated mid-October 2025. Alternative soluble oral corticosteroids remain available and can support increased demand.

Medicine Supply Notification: Abidec® Multivitamin drops

Abidec® Multivitamin drops are out of stock until further notice. Dalivit® oral drops remain available but can only support prescription demand. Alternative multivitamin drops remain available.

Specialist Pharmacy Service

Managing interactions with methotrexate
Page updated to include section on trimethoprim and co-trimoxazole

Safe handling of monoclonal antibodies
New published page on the considerations for occupational safety when preparing monoclonal antibodies

Oral benzodiazepines and choosing equivalent doses
Full page update – Factors to consider before switching between oral benzodiazepines.

Switching between aminophylline and theophylline in adults
Full page update – Guidance on switching between oral theophylline and IV aminophylline.

Using transdermal patches safely in healthcare settings
Full page update and split into series – Guidance on the application, monitoring, removal, disposal, documentation and storage of transdermal patches to reduce risk of medication errors.

The risks and principles of prescribing in pregnancy
Full page update – Guidance on the key risks and principles to ensure safe informed decisions in prescribing in pregnancy.

National guidance, publications and resources

NPPG – Position statement on the off-label use of chloral hydrate to sedate neonates and children in critical care

Updated July 2025, in consultation with the Paediatic Critical Care Society. Chloral hydrate initiation in paediatric critical care should be consultant-led, after ensuring that all other appropriate pharmacological and non-pharmacological sedative treatments have been optimised

UKHSA – Updated information about the use of paracetamol to prevent and treat fever after MenB vaccination

The advice on the use of paracetamol following MenB vaccination differs to previous advice on the use of paracetamol for post-vaccination fever which may still appear on infant paracetamol product packaging.
To avoid confusion, the UKHSA have produced a patient information leaflet detailing advice on paracetamol dosage and timings and addressing frequently asked questions. Every parent or guardian should be given a copy at the 8-week immunisation appointment.

National guidance, publications and resources

HSSIB - Sepsis: investigating under the Patient Safety Incident Response Framework (PSIRF)

Although sepsis has been the focus of extensive national work, it has persisted as a safety risk. The themes from incidents and complaints have remained the same over time. Evidence from the intelligence gathered suggests that greater insight into the challenges faced at an organisational level in recognising sepsis would be helpful.

To support NHS organisations and local investigation staff, we identified an opportunity to model approaches to patient safety incidents investigations (PSIIs) under the NHS Patient Safety Incident Response Framework (PSIRF). Stakeholders told us that this would help to increase local learning and provide examples of how PSIRF tools can be used to improve investigations. We have also used this opportunity to identify learning that may help to improve how PSIRF can support staff in carrying out incident investigations.

BNF - Adrenaline auto-injectors for acute anaphylaxis

Following a review of dosing of adrenaline/epinephrine auto-injector devices for acute anaphylaxis, the body-weight ranges for Jext® have been aligned with those of EpiPen® so that all children weighing ≥25kg may be given a dose of 300 micrograms.

National guidance, publications and resources

MHRA – Yellow Card Biobank – GLP1's and acute pancreatitis

The pioneering Yellow Card Biobank, launched by the MHRA and Genomics England, will start investigating whether the risk of acute pancreatitis from GLP-1 injections for weight loss and Type 2 diabetes may be influenced by an individual's genes. Patients who have been hospitalised with acute pancreatitis suspected to be related to glucagon-like peptide-1 receptor agonists such as Ozempic and Mounjaro, are being asked to report it to the MHRA's Yellow Card scheme. Healthcare professionals are also being asked to help recruit for the study by reporting Yellow Cards on behalf of patients experiencing acute pancreatitis while taking GLP-1 medicines.

HSSIB - Workforce and patient safety: electronic communications on patient discharge from acute hospitals

This investigation report is published under HSSIB's workforce and patient safety theme. This report is intended for healthcare policy makers to help influence improvements in patient safety. It is also intended for those who work in and engage with providers of primary, community and secondary care, including integrated care boards (ICBs). While the investigation did not focus on transfers of care between other health and social care settings, findings are likely to be relevant to these providers.

Prevention of Future Death Reports (Regulation 28)

Simon Hockenhull: Prevention of Future Deaths Report

Ref: 2025-0295

Mr Hockenhull was diagnosed with diabetes in 2017. Since diagnosis, he had struggled to manage the condition, which led to gastro-intestinal issues; this in turn made him more prone to contracting infections and more vulnerable when he did contract them. In 2024, his diabetic control significantly worsened resulting in multiple trips to the ICU over that year due to diabetic ketoacidosis. On 5 December, he was found collapsed but breathing at his home. His brother called emergency services, but by the time paramedics arrived, Mr Hockenhull had died. Mr Hockenhull died due to contracting lobar pneumonia, contributed to by his underlying diabetes and diabetic gastroenteropathy which materially reduced his resilience.

The coroner highlighted the following concerns:

- Some diabetic medications and devices have 14-day lifespan. When two are prescribed, this equates to a 28-day supply. However, this can create issues as some pharmacists interpret a 28-day supply as a full calendar month which in turn makes it challenging to obtain a further prescription within the same calendar month.
- For individuals who already face challenges managing their medication, these obstacles can further disrupt adherence. As a result, they may not take their medication as consistently as required compromising their health. For diabetics this can have a significant impact on their health, including developing diabetic ketoacidosis.
- The RCGP RPS "Repeat Prescription Toolkit" (October 2024) does not seem to address the issue of a "month" being inconsistently defined.

Prevention of Future Death Reports (Regulation 28)

Michael Barry: Prevention of Future Deaths Report
Ref: 2025 – 0296

Mr Barry had a long-standing history of mental health problems and illicit drug and alcohol misuse. By the time of his death Mr Barry's use of illicit drugs had significantly diminished (though he continued to 'binge drink' to excess). However, he had developed a long-standing dependency on prescribed opiate based pain-killing medication (Codeine) following significant surgery some years prior to his death.
Although the source of the codeine was not disclosed, the lack of specialist support to which the GP could refer the patient due to dependence was a significant concern.

The coroner highlighted the following concerns:

- There remains no specialist commissioned service available for GPs to which they might refer their patients to manage reduction of their intake of prescribed dependency-forming medications. This is in contrast to the availability of commissioned services for patients who are dependent on illicit drugs and/or alcohol.

Prevention of Future Death Reports (Regulation 28)

Susan Young: Prevention of Future Deaths Report
Ref: 2025-0322

Miss Susan Young suffered various cardiac problems, including a previous heart attack. She was also prescribed a medication for epilepsy which has the side effect of prolonging the QT interval and can precipitate cardiac arrhythmias. Miss Young was admitted to hospital after taking an overdose of prescription medication on the 22nd August 2024. She was monitored appropriately whilst in the emergency department and transferred to a ward with directions that she be attached to cardiac monitoring. When nursing staff took her to the ward, they did not give any handover and certainly no instructions about cardiac monitoring.

Miss Young took a further intentional overdose the next day and was found unresponsive and not attached to any monitoring; resuscitation failed, and she was declared deceased in bed by nursing staff on the 23 August 2024. It is thought that the medication may have had a cumulative effect. When the nurses were packing up her belongings, they found more unused medication which had been left with the patient. It is not known if she had taken any of this.

The coroner highlighted the following concerns:

- There was no appropriate handover i.e. cardiac monitoring to the receiving ward.
- Patient's own medication was found in her belongings that allowed the opportunity for further overdose.

Prevention of Future Death Reports (Regulation 28)

Aaron Atkinson: Prevention of Future Deaths Report
Ref: 2025-0329

Mr Atkinson was found unexpectedly deceased on the morning of 20 April 2023 at his home address. Aaron's mother was doubtful of the cause of death proposed and pressed for a second postmortem which was undertaken by a different pathologist. That pathologist considered that a more likely cause of death was cardiac arrhythmia caused by Aaron's prescription of risperidone (for behavioural regulation), and methylphenidate (for ADHD). The court notes that Aaron's medication reviews to check for any complications were conducted in line with local health guidelines. Aaron's last review took place in November 2021, but Aaron did not attend subsequent reviews which were offered.

The coroner highlighted the following concerns:

- Whilst Aaron had annual GP reviews related to prescription of anti-psychotic medication to check for signs of adverse side effects and physical health complications, those reviews did not include ECGs to check for signs of adverse effects on electrical activity of the heart. On the medical evidence before the inquest - antipsychotic medication carries recognised risk of QT interval prolongation and lethal cardiac arrhythmias.
- It does not appear that the recognised risk of QT interval prolongation and lethal cardiac arrhythmias from long term prescription of antipsychotic medication is reflected in guidance to medical practitioners and prescribers, nationally or locally in terms of performing ECGs. The relevant NICE guidance refers to ECG testing under *How should I monitor someone taking antipsychotics?* and recommends *Electrocardiography (ECG) – after dose changes. Ideally, also annually.*
- It appears there is lack of clarity and consistency for annual reviews to include ECGs where people are prescribed antipsychotic medication long term. Given the recognised risks explained at inquest then not providing annual ECGs for long term users of those medications appears to pose risk of death.

Primary research - Medication Safety

Impact of collaborative pharmaceutical care on older inpatients' medication safety: multicentre stepped-wedge cluster randomised trial (MEDREV Study)

This multicentre trial in French hospitals found that collaborative pharmaceutical care (CPC) — involving pharmacists in medication reconciliation and review — significantly reduced medication errors at hospital admission, from 88.9% to 29.2%. The study highlights pharmacists' crucial role in improving inpatient medication safety and reducing harm.

Leguelinel-Blache G, Bouvet S, Bedouch P, Bachelet B, Chenailler C, Dantin T, Geneletti L, Janes A, Scher F, Cireașă B, Kinowski JM, Castelli C, Roux-Marson C; Working Group "Valorisation of Pharmacist Interventions" of the French Society of Clinical Pharmacy; MEDREV working group. Impact of collaborative pharmaceutical care on older inpatients' medication safety: multicentre stepped-wedge cluster randomised trial (MEDREV Study). BMC Geriatr. 2025 Jul 11;25(1):516. doi: 10.1186/s12877-025-06122-1. PMID: 40646458; PMCID: PMC12247195.

Primary research - Medication Safety

Risk factors for unintentional medication discrepancies identified through pharmacy staff-led medication reconciliation to prioritise patients in the emergency department: a rapid review

Advanced age and polypharmacy were consistently associated with unintentional medication discrepancies. Future research should address variations in health IT systems and focus on developing robust prioritisation models to optimise medication reconciliation processes and improve patient safety. Increasing pharmacy staff capacity may further support this goal.

Review of patient safety across the health and care landscape

Dr Penny Dash's review of patient safety across the health and care landscape in England, which was commissioned by the Department of Health and Social Care.