Italy	Yes 1) Review of State Governments' recommendations for The Prevention of Adverse Events and Sentinel Events; 2) Review of the National Best Practices and Guidelines on Patient Safety and Clinical Risk Management	Revisione delle Raccomandazioni Ministeriali in tema di Sicurezza delle Cure	AGENAS: https://www.agenas.gov.it/	Not sure; prosumably governmental funds	Update national Patient Safety recommendations and best practices	Patients, healthcare professionals and institutions	voluntary; no financial support is being received	More then 4 years	Infection Prevention and Control, Falls, Medication without Harm, Midwifery	Initiation & planning phase	Type 2 N° of Sentinel Events, N° of Lawsuites and Claims, N° of Initiatives involving patients	Yes. Training and educating stakeholders (e.g., conducting ongoing training, developing training materials)	Type 3: primary focus on implementation; secondary focus on effectiveness	No results available yet	AGENAS is the national agency on best practices and guidelines which will regard these aspects		
UK	Yes HSIB, Academic Health Science Network , NHS England (National Patient Safety Syllabus, FSRP, MatObsESP, MatNeoSP, MedSP, A&S-SIP, MH-SIP), National Institute for Health & Care Research	HSIB	https://www.hsib.org.uk/	Department of Health & Social Care. Approx£4 million p.a.	To undertake national investigation to lead to system level change and improve patient safety	All/groups	Voluntary until 01/10/23 then mandatory; No financial support being received	More then 4 years	All/NHS sectors in England	Permanent organisation in transition;	Type 1 and 2. Never-event reporting and effect of training on quality of investigations	Yes. An education programme with approximately 11,000 learners. Programme aimed to establish webinars for learning from investigations. Engagement with stakeholders across the system, regular meetings, roundtables and	We focus on recommendations, not implementation	A need to have more impact and an exploration now of a thematic approach to achieve more impact	Continually reported to DHSC; Reports available on the website		
Switzerland	Yes - Program on Knowledge Generation and Allocation - Program on Risk monitoring and reduction - Various programs on Infection Control (e.g. safe surgery including checklists, vaccinations - Various programs on national hygiene surveillance and intervention - Various audit programmes - Various national quality improvement programs - Various accreditation programs	Surgical Site Infections Intervention of Switch/KOSO	https://www.swissnoso.ch/medias/sso-intervention/sarker-sso-intervention/sso-modul	Not known by expert	Surveillance and reduction in surgical site infections	Experts involved in surgical interventions	Voluntary; No financial support being received	More then 4 years	in-hospital and ambulant settings	Execution Phase	Type 1	Yes; Training and education	Type 1: primary focus on effectiveness; secondary focus on implementation	Not known by expert	Webpage and regular publications		
Scotland	Yes	Scottish Patient Safety Programme	https://hub.scot/improvement-programmes/scottish-patient-safety-programme-spsp/	Direct funding from Scottish Government to Healthcare Improvement Scotland who run the programme. Not discreetly funded as a separate entity	To improve the safety and reliability of care and reduce harm	All healthcare and social care staff	Voluntary; No financial support being received	More then 4 years	Acute Adult Healthcare Primary Care Mental Health Specialties (including neonatal and maternity care) Paediatrics	Execution Phase	Types 1, 2 and 3	Yes including training, development and support for teams.	Type 2: equal focus on effectiveness and implementation	The programme is an ongoing improvement programme with a number of successful initiative demonstrated, but which continue to be worked on.	Published on the SPSP Website		
Belgium	Yes One program is over the psychiatric hospitals One other is in the continuity of 2 national patient safety programs of 4 years, we decided to start with a Pay For Performance program wich is based on quality indicators related to patient safety or quality of care	PAP for general hospital	https://www.health.belgium.be/fr/programme-pay-performance-p4p-pour-les-hopitaux-generaux-0	The federal authority of Health pays the program, for now the budget is 7 millions euros, we foreseen to increase it to 1% of the funding for the general hospitals in the coming years	to give incentive for the hospitals who can reach a level of quality (available using quality indicators) and stimulate the hospitals to invest on the area of patient safety to increase the awareness of healthcare practitioner, the hospital management and the patients	Hospital Staff	Voluntary; Yes financial support received	More then 4 years	Hospital Sector	Execution Phase	Type I & 2	Yes, at different level we organize trainings with the universities and we try to develop a network of experts on the topic	Type 1: primary focus on effectiveness; secondary focus on implementation	we see data to evaluate hospitals and the quality of the dates in prov we also need new dates without asking hospitals to register them a good collaboration between different administrations is important	Items are published in an aggregated form on the dedicated website		
Austria	Yes Austrian Health Literacy Alliance - Citizens and Patient Empowerment	Citizens and Patient Empowerment & patient centred communication	https://oegkk.at/buerger-und-patientenempowerment https://oegkk.at/gute-gespraeche/aquilibeli-im-gesundheitssystem/	Austrian Ministry of Health & Federal Health Agency; € 455.000,-	Patient empowerment in doctor patient communication Training of health professionals in patient centered communication	Patients with chronic diseases; doctors, nurses, physiotherapists	Voluntary; Yes financial support received	More then 4 years	hospitals, rehabilitation services, primary health care	Execution Phase;Monitoring & Controlling Phase;	patient satisfaction; adoption & penetration training outcomes for participating health professionals (Type 1, 2 and 3)	National strategy "Improving the quality of conversation in the Health Care. Strategy for establishing a patient-centred communication culture https://oegkk.at/wp-content/uploads/2018/10/strategie-zur-verbesserung-der-gespraechsqualitaet.pdf	Type 3: primary focus on implementation; secondary focus on effectiveness	The communication trainings are well accepted by participants with strong impact on their communications skill.	Ammerstorp, Jette; Bigi, Sarah; Silverman, Jonathan; Sator, Marlene; Gillen, Peter; Ryan, Winifred; Rosenbaum, Marcy; Chriswell, Meg; Doherty, Eve; Martin, Peter (2021): Communication skills training – lessons learned from international initiatives. In: Patient education and counseling 104(2:352-359 Sator, Marlene; Holler, Peter; Rosenbaum, Marcy (2021): National train-the-trainer certificate programme for improving healthcare communication in Austria. In: Patient education and counseling 104:2657-2660 https://www.sprechen-wie-wir-sprechen.at/sprechen/wie%20wir%20sprechen/patient/a/map/home.htm	IT is important to invest in patient centered communication to improve patient safety In my opinion, there has been a positive evolution of the indicators and, most importantly, a change in the culture within healthcare centers regarding patient safety.
Spain	Yes, At national and regional levels. National strategy plus patient safety programs in each of the autonomous communities	Mejorar seguridad pacientes Estrategia de Seguridad del Paciente del Sistema Nacional de Salud. Periodo 2015-2020 File pdf. Will open in a new window	https://www.semded.es/wp-content/uploads/2015/10/Estrategia_Seguridad_Paciente_Sistema_Nacional_Salud_Periodo_2015_2020.pdf https://www.mscbs.gob.es/profesionales/excelencia/excelCalidadSNS/excelencia/map/home.htm	Health Ministry but actions are funded by each autonomous community	Improve & ensure patient safety	patient, workers, society as a whole	Voluntary; Yes financial support received	2-4 Years	public and private	Monitoring & Controlling Phase	Several indicators are available on the Net (in Spanish)	Yes, diverse strategies have been developed	Type 2: equal focus on effectiveness and implementation	Are available on the Net			
UK	Yes. We have a National Patient Safety Strategy - https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/ - with three strategic aims, freight, Involvement and Improvement, based on the underpinning foundation of safety systems and culture. Each of these strands have a number of national safety programmes sitting underneath them. For example key delivery programmes, include the introduction of the new Patient Safety Incident Response Framework, the new Maternity and Patient Safety Events service, Patient Safety Specialists, and the NHS Patient Safety Syllabus. As well as the national patient safety improvement programmes covering areas of mental health, medicines, maternity/neonatal and a Framework for involving patients in patient safety. For the full list, please see the strategy website.	National Patient Safety Strategy	https://www.england.nhs.uk/publication/the-nhs-patient-safety-strategy/	There is a national patient safety team, but no specific budget allocated to deliver the national patient safety strategy. Organisations do not receive a designated patient safety budget, it is incorporated into their overall budget for service delivery. In addition, the National Patient Safety Team commissions Academic Health Science Networks (AHSNs) to deliver improvement support through Patient Safety Collaboratives" in delivering key national safety improvement programmes as part of the wider strategy delivery. "Patient Safety Collaboratives are made up of the NHS providers and commissioners in a geographical region with each hosted by one of 15 regionally based AHSNs.	Overarching aim is to Deliver the Patient Safety Strategy and patient safety statutory duties that we have estimated could save an additional 1,000 lives and £100 million per year from 2023/24. Objectives - •Monitor and support the development of a positive safety culture and systems in the NHS •Improve our understanding of patient safety in the NHS (insight) •Increase capability and capacity to address safety challenges across the NHS (involvement) •Focus on key improvement priorities where additional national activity can add value (improvement).	Patients and staff - Different aspects of the strategy are aimed at more specialist groups, for example patient safety specialists, pharmacists etc. However, the whole strategy is aimed at both patients and staff across health and social care, including regulatory bodies and other arms length bodies.	Some areas are mandated in NHS contracts; no financial support	More then 4 years	All areas - acute, community, mental health, ambulances, primary care, specialist provision, as well as social care (ie care homes)	Execution Phase	Type 1, 2 and 3 Examples of key deliverables include and cover service, patient/staff and implementation outcomes; • Agree plans to link patient and staff safety, to address patient safety in primary care and to address patient safety inequalities by Q2 23/24 (Type 2 - staff survey) • Implement the Learn From Patient Safety Events service in all NHS trusts by Q4 23/24 (type 3) • Implement the NHS Patient Safety Incident Response Framework in all NHS trusts by Q4 23/24 (type 3) • Roll-out ME scrutiny of deaths in the community throughout 23/24 (type 2 and 3) • Consult on options to revise the Never Events Framework by the end of Q2 23/24 (type 1 and 2) • Continue implementation of the Framework for Involving Patients in Patient Safety, ensuring safety committees have at least 2 Patient Safety Partners (type 1 and 2) • Evaluate the patient safety specialists role and implement training for all patient safety specialists in levels 3 and 4 of the syllabus (type 1 and 2) by Q4 23/24 • Develop and implement patient safety improvement programmes including reducing harm from high strength opioids and direct oral anticoagulants through 23/24, implementation of Maternal Early Warning Scores and Neonatal Early Warning Trigger and Track Scores and Paediatric Early Warning Scores across 23/24 and exploring clinical issues like VTE, pressure ulcers, hydration and fluid balance (type 1)	Strategy is supported by the development of a National Patient Safety Syllabus, a network of Patient Safety Specialists and the introduction of Patient Safety Partners.	Type 2: equal focus on effectiveness and implementation	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. 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 and Review and response case studies 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 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 Work supported by the Medication Safety Team to reduce incidents 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 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 overdoses. 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) are reporting improved safety cultures, identification of more effective risk reduction strategies and early signs of harm reduction, due to their revised approach. We estimate that there are 1,200 unexpected deaths in maternity services every year, each one representing a potential death or severe harm event, due to a focus on reducing risks through the Never Events Framework and National Patient Safety Alerts (NPSAs). 11,621 care homes have been engaged on work to improve management of patient deterioration. This leads to reduced 999 calls, fewer emergency admissions and shorter lengths of stay. Read our Supporting care homes to identify deterioration case study 38 mental health wards piloting work on restraint, seclusion and rapid tranquillisation have seen a 15% reduction in those practices.	https://www.england.nhs.uk/publication/the-nhs-patient-safety-strategy/the-patient-safety-strategy-progress-so-far/	
Australia	Yes. 'Details can be found here on the website of the Australian Commission for Safety and Quality in Healthcare. Each State and territory also have safety priories which align with these national programs. www.safetyandquality.gov.au	Expert answer: I don't think it is possible to identify the most significant programs. I have strong interests in medication safety but acknowledge there are many other important programs.	www.safetyandquality.gov.au	Federal Government funds the National programme. Budget known. The timeframe varies for the different sub programs	See website	See website	.	More then 4 years		Initiation Phase;Planning Phase;Execution Phase;Monitoring & Controlling Phase;Closure Phase ;Multiple elements of the program;	See website and national quality standards www.safetyandquality.gov.au	Yes for some program areas	Type 2: primary focus on implementation; secondary focus on effectiveness	See website	See reports on the website	