Health Services Safety Investigations Body

Interim bulletin 2

Harm caused by delays in transferring patients to the right place of care

Date Published:
16/07/2024

Theme:
Emergency care

This PDF was downloaded from the Health Services Safety Investigations Body (HSSIB) website. To make sure you are reading the latest version, and for accessible reports, please visit https://www.hssib.org.uk

Contents

Introduction

Background

Emergent findings

Patient safety risk management and accountability

Observed patient safety management in health and social care

Accountability and responsibility for patient safety

Patient safety at health and social care integration points

Patient safety strategy

Staff wellbeing

References

Introduction

The aim of this second interim bulletin is to provide an update on the investigation's initial findings, which were published in an interim bulletin on 16 June 2022. A link to the first interim bulletin can be found here. The first bulletin includes a detailed background to this investigation and two safety recommendations. This second interim bulletin focuses on patient safety risk accountability.

Background

Delays in transferring patients to the right place of care are causing harm to both patients and healthcare staff. For example, extended ambulance response times and delays in transferring patients to the right place of care (such as from an ambulance to the emergency department, or in discharging a patient from hospital to social care) are impacting on patient safety throughout the healthcare system. This national investigation seeks to examine the systems that are in place to manage the flow of patients through and out of hospitals, and considers the interactions between the health and social care systems (the 'whole system').

Emergent findings

The investigation engaged with a broad range of stakeholders regarding the patient safety impact:

- of patients remaining in hospital when that is no longer the most appropriate place of care for them, including the effect of this on patient flow through a hospital
- on patients and staff when ambulances queue outside emergency departments.

The findings presented below were identified following:

- discussions with integrated care boards (ICBs)
- observational visits to ambulance services and acute healthcare settings
- focus groups with a broad range of staff working in the ambulance service and NHS 111 call-handling centres
- discussions with national organisations
- engagement with senior operational staff across the NHS and social care.

Patient safety risk management and accountability

Each part of the healthcare system manages an individual patient's safety risk in isolation. ICB staff told the investigation that they are developing the ability of their organisations to manage risks across the system. However, when a patient's journey reaches the boundary between health and social care, there seems to be an 'air gap' where patient safety is not managed in either direction (see figure 1). This means that, because risks are not understood or managed, patients have an increased chance of poor outcomes.

Healthcare system leaders told the investigation that a whole-system national emergency response is required.

Observed patient safety management in health and social care

Figure 1 Simplified diagram of degree of risk to patient safety as a patient moves through the healthcare system to social care

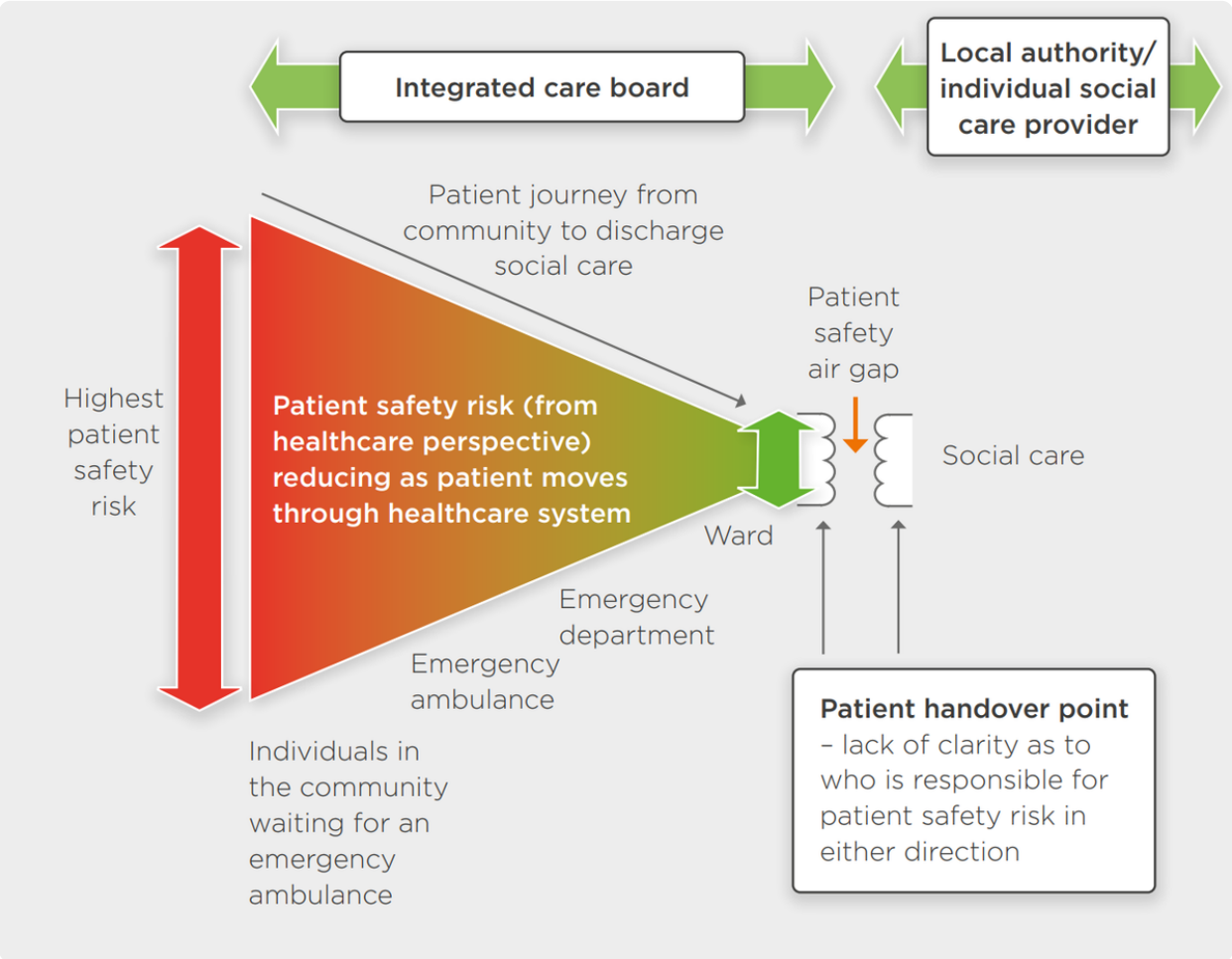


Figure 1 shows the patient safety risk across the healthcare system, as observed by the investigation. The investigation recognises that managing patient safety is not a linear process; it is multidirectional and will change throughout the system. The investigation also recognises that certain situations may increase the patient safety risk, for example, when there are staffing or equipment challenges. In general, however, figure 1 describes a decreasing patient safety risk as patients move through the healthcare system toward discharge to the right place of care.

The investigation heard from healthcare leaders that the patient safety risk is highest when a patient needs an emergency ambulance. The risk of serious harm may increase the longer the patient waits for an ambulance to attend the scene and is an ‘unknown’ risk at this time. Once the patient has arrived at hospital, they may have to remain in the back of the ambulance until they can be admitted to the right place of care. For example, a patient may be transferred into the emergency department or stroke unit, where they will receive a different level of care than is possible in an ambulance.

The investigation observed that while in most cases the patient safety risk reduces as a patient moves through the healthcare system, inefficient flow through a hospital can increase the risk. For example, the investigation observed significant numbers of medical patients (such as those patients with difficulties relating to diabetes) receiving care in ward settings that were primarily intended for use by non-medical specialties (for example a surgical ward). Patients cared for in such settings are termed ‘medical outliers’. While the environments in which medical outliers are treated may lend themselves to more appropriate care than the back of an ambulance, the ability to provide safe and effective care may be impaired.

Accountability and responsibility for patient safety

ICBs were formed on 1 July 2022 under the Health and Care Act 2022 to replace clinical commissioning groups. The purpose of an ICB is to commission and manage local healthcare services in its geographical area of responsibility to meet the needs of the local population. ICBs work with integrated care partnerships (ICPs). Under the Health and Care Act 2022, the role of an integrated care partnership is to ensure that health and social care operate in a cohesive manner to serve the health of the community.

Senior ICB staff told the investigation that, while they are only in the early stages of their development, their responsibilities include assessing, reporting and, where necessary, escalating risks and issues that may directly impact patient safety. However, they stated that when a patient pathway requires input from social care providers, the person or organisation for managing patient safety risks is less clear. This is because the risks span the boundary

between health and social care (see figure 1). HSIB has identified that there is now an opportunity for the whole-system to review its patient safety operating model before ICBs and ICPs become too established in their ways of working.

ICB staff told the investigation that there is a real willingness among healthcare and social care providers to work together. However, formal partnership working across health and social care is in its very early stages. Many staff said that where the whole system works well, this is a result of good will and strong interpersonal relationships, as opposed to organisational structures, governance and operating frameworks.

NHS England told the investigation that they believe the patient safety risk is managed across the boundaries of health and social care in a coordinated manner by ICPs. However, the investigation observed that the reality did not match this perspective. The investigation witnessed inconsistencies in how individual ICBs communicate with, interact with, and respond to different health and social care providers and local authorities within their region. The investigation was told that this is in part because of historical organisational arrangements, and the different ways services were commissioned and how their performance was managed. In addition, organisations have different and competing priorities, which can make standardisation of processes and management of patient safety more complex.

Health and social care leaders described some examples of where the system is not working efficiently and effectively:

- It is not always possible to discharge a patient from hospital into the right place of care. The investigation found specific examples of where this was an issue, for example when a social care setting does not have an admission management structure in place at weekends to accept new patients or residents.
- If a patient is discharged from hospital to a suboptimal or incorrect social care setting, that patient may need to be readmitted to hospital shortly after discharge. This creates more pressure in the system, impacting capacity and patient flow through hospitals, and potentially having a detrimental effect on that and other patients' safety.

A senior local authority representative told the investigation that "Care homes are exactly that – a home." Local authority stakeholders described how they try to place people being discharged from hospital into a home in which they will be comfortable and where they will have the best chance to integrate with the home's community. They said that it can be challenging to find the right social care setting for an individual who has additional healthcare needs along with their social care needs. Placing a person in an inappropriate care home solely to free up a hospital bed to relieve pressure in the healthcare system, may risk losing the patient centred focused approach to social care placements.

Patient safety at health and social care integration points

The health and social care systems interface with each other not only when a patient is handed over from one system to the other, but also at other points. For example, the social care system may be involved in hospital discharge planning early in a patient's journey through the healthcare system. However, health and social care have competing priorities and a different tolerance for risk. For example, there are differences in how each sector manages infection control, and in how they balance the needs of people already in a care home against those of patients who are waiting to be discharged from hospital. In addition, they operate under different governance and financial arrangements. The two sectors are therefore not truly integrated, and this presents a challenge to ensuring patients are in the right place of care.

Patient safety strategy

NHS England has a patient safety strategy (NHS England, n.d) which is being updated. The investigation was told that this updated strategy will not define the individuals or organisations who are accountable for patient safety risk.

In other safety-critical industries, nominated individuals are personally accountable for safety risks and clearly defined frameworks ensure that each individual understands their own accountability and responsibilities. For example, all airlines in the UK (and throughout most of the world) are required, by law, to operate a safety management system. This is a familiar concept in other safety-critical industries, and ensures that safety is considered in a systematic and proactive way with goal setting, planning and assurance, as well as measurement of performance. This requires accountability from the top of an organisation, and allows safety to be actively managed in the same way – and with the same priority – as performance and funding (Healthcare Safety Investigation Branch, 2022).

NHS England have produced an Operating Framework which describes the roles that NHS England, integrated care boards (ICBs) and NHS providers will now play, working alongside our partners in the wider health and care system (NHS England, 2022). However, as discussed in HSIB's interim bulletin 1 (link) individual parts of the system are unable to influence the whole-system and therefore carry risks that they cannot mitigate or manage. Furthermore, the Operating Framework does not specifically define individual accountability and goal setting for patient safety. The investigation has not observed such a regulated whole-system safety management system in health and social care.

HSIB makes the following safety observation

Safety observation O/2022/197:

It may be beneficial for there to be a whole-system patient safety accountability and responsibility framework that spans health and social care.

Staff wellbeing

The investigation spoke to staff working in urgent and emergency healthcare about their wellbeing. Staff described the detrimental impact on their personal health and wellbeing resulting from not being able to help the sickest people.

Staff told the investigation that they were often unable to switch off from work. Some gave examples of this causing reduced attention levels at work and their ability to deliver the best service possible for their patients. It was also described as having an impact on their personal relationships at home.

The investigation heard the following common words from staff working across urgent and emergency care:

- helplessness
- hopelessness
- frustration
- anger
- tiredness
- fatigue
- despair
- but … “It’s our job and we will keep on going.”

The investigation is working with stakeholders and a subject matter advisor to understand how deteriorating staff wellbeing can impact safe patient care and will report further when this work is complete.

References

Health and Care Act 2022 [Online]. Available at https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted (Accessed 23 September 2022).

Healthcare Safety Investigation Branch. (2022). Letter from HSIB Chief Investigator to the Secretary of State for Health and Social Care.

NHS England. (n.d.) The NHS patient safety strategy [Online]. Available at https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/ (Accessed 4 October 2022).

NHS England. (2022) NHS England operating framework [Online]. Available at https://www.england.nhs.uk/publication/operating-framework/ (Accessed 13 October 2022).

© 2026 HSSIB.