



House of Commons
Public Administration
and Constitutional Affairs
Committee

**Follow-up to PHSO
report on unsafe
discharge from hospital:
Government Response
to the Committee's
Fifth Report of Session
2016–17**

**Third Special Report of Session
2016–17**

*Ordered by the House of Commons to be printed
7 February 2017*

Public Administration and Constitutional Affairs

The Public Administration and Constitutional Affairs Committee is appointed by the House of Commons to examine the reports of the Parliamentary Commissioner for Administration and the Health Service Commissioner for England, which are laid before this House, and matters in connection therewith; to consider matters relating to the quality and standards of administration provided by civil service departments, and other matters relating to the civil service; and to consider constitutional affairs.

Current membership

[Mr Bernard Jenkin MP](#) (*Conservative, Harwich and North Essex*) (Chair)

[Ronnie Cowan MP](#) (*Scottish National Party, Inverclyde*)

[Paul Flynn MP](#) (*Labour, Newport West*)

[Marcus Fysh MP](#) (*Conservative, Yeovil*)

[Mrs Cheryl Gillan MP](#) (*Conservative, Chesham and Amersham*)

[Kate Hoey MP](#) (*Labour, Vauxhall*)

[Kelvin Hopkins MP](#) (*Labour, Luton North*)

[Gerald Jones MP](#) (*Labour, Merthyr Tydfil and Rhymney*)

[Dr Dan Poulter MP](#) (*Conservative, Central Suffolk and North Ipswich*)

[John Stevenson MP](#) (*Conservative, Carlisle*)

[Mr Andrew Turner MP](#) (*Conservative, Isle of Wight*)

The following members were also members of the committee during the Parliament: [Oliver Dowden MP](#) (*Conservative, Hertsmere*), [Adam Holloway MP](#) (*Conservative, Gravesham*), [Mr David Jones MP](#) (*Conservative, Clwyd West*) and [Tom Tugendhat MP](#) (*Conservative, Tonbridge and Malling*).

Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No. 146. These are available on the internet via www.parliament.uk.

Publication

Committee reports are published on the Committee's website at www.parliament.uk/pacac and in print by Order of the House.

Evidence relating to this report is published on the [inquiry publications page](#) of the Committee's website.

Committee staff

The current staff of the Committee are: Dr Rebecca Davies (Clerk), Ms Rhiannon Hollis (Clerk), Dr Sean Bex (Second Clerk), Jonathan Bayliss (Committee Specialist), Ms Penny McLean (Committee Specialist), Rebecca Usden (Committee Specialist), Mr Alex Prior (PhD Scholar), Ana Ferreira (Senior Committee Assistant), Iwona Hankin (Committee Assistant), and Mr Alex Paterson (Media Officer).

Contacts

All correspondence should be addressed to the Clerk of the Public Administration and Constitutional Affairs Committee, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 3268, the Committee's email address is pacac@parliament.uk

Third Special Report

The Public Administration and Constitutional Affairs Committee published its Fifth Report of Session 2016–17, [Follow-up to PHSO report on unsafe discharge from hospital](#), as HC 97 on 28 September 2016. The Government Response was received on 24 January 2017 and is appended to this report.

Appendix: Government Response

Following the Public Administration and Constitutional Affairs Committee's (PACAC) recent inquiry into the issues raised in the Parliamentary and Health Service Ombudsman's (PHSO) report *A report of investigations into unsafe discharge from hospital*, published 16 May, and the Committee's subsequent follow-up report on the matter, I am writing to set out the Government's response.

I recognise the importance of the issues raised by the PHSO and welcome the scrutiny of the PACAC into this important area of care. The report covers three main areas as follows: understanding the problem; barriers to best practice implementation; and national responsibilities for improving discharge practice. I will address these issues, referencing the particular areas of concerns highlighted by the PHSO, in my response.

Government response to the Committee's conclusions and recommendations

1) All patients deserve care that is safe, effective and delivered to a high standard. Health and care services should work together to ensure that patients are clinically ready for discharge, and that where ongoing care needs are identified, those needs are met. However, the PHSO report made clear that there have been circumstances where health and care services fell short of the high standards they hold themselves to, and we expect of them.

2) Whilst it is important to point out the PHSO did not suggest the cases outlined were indicative of a system-wide problem, we are not complacent about the wider issues within the system that can contribute to such failings in care. In the evidence provided to the Committee, both prior to the hearing and during the hearing itself, we made clear the wider systematic changes that needed to be effected if we are to deliver: care that is joined up; services that are integrated; and treatment that can be provided in the community and closer to home. We believe that through local Sustainability and Transformation Plans, innovative new models of care, and increasing integration of health and social care we will ensure that services are more sustainable, more responsive and more closely aligned to the needs of the populations they serve. There is also a range of actions underway to improve discharge processes, spread best practice and collect new data about discharge in hospitals.

Understanding the problem

(1) Discharging patients before they are ready

There remains a need to improve the data to better understand both the extent to which patients are discharged before they are ready, and the relationship between early discharge and readmission. The Secretary of State for Health and the NHS must set out, as part of the Government response to this report, how they will improve understanding of the scale of early discharge and its impact in terms of unplanned readmission. (Paragraph 20)

3) No patient should be discharged before they are assessed as being medically ready to leave hospital. However, patients who are medically ready may still be very frail, confused, and in need of ongoing care. It is important that nursing homes, social services, community health and families fulfil their obligations when a patient is discharged, to avoid an emergency readmission for something as avoidable as a fall or dehydration. The number of patients who fail to receive the timely hospital care they need because of patients who are in hospital and are medically fit for discharge is a significant issue for the NHS, which must be considered alongside the risks of unsafe discharge. However, the decision to discharge a patient is a clinical matter and, as such, the determination of whether or not a decision to discharge was clinically appropriate or not can only be established through rigorous investigation, undertaken on a case by case basis.

4) Hospital readmissions can occur for a multitude of reasons. Readmissions data are used as an indicator to measure success in helping patient recovery, both nationally and locally, and are monitored by the Department, NHS England and Public Health England. However, the guidance alongside these data makes it clear that it should not be viewed in isolation, but should instead be considered and interpreted alongside information from other indicators and alternative sources of intelligence such as patient feedback and staff surveys. There can be multiple agencies involved in providing out of hospital support to recently discharged patients, and a shortcoming in the delivery of any one aspect of care could contribute to a readmission. It is also the case that not all readmissions are preventable, even in circumstances where all a patients' care needs are met.

5) Specifically on patient safety, we know that around 14,000 reports of incidents related to discharge or transfers of care are made to the Patient Safety National Reporting and Learning System Annually (NRLS) annually and around 10,000 of these relate to discharge from acute hospitals. They demonstrate staff recognise and report situations where they are concerned that a patient was not well enough to go home or did not have the full package of care they needed. However, these are predominantly no harm or low harm incidents (no harm and low harm together make up around 96%) and typically relate to delays in obtaining medication or equipment to take home or poor communication. It is also important to point out that for older patients, remaining in hospital can cause decompensation, further leading to worse outcomes including greater disability, and higher likelihood of death or placement in institutional long term care. The decision to discharge therefore requires careful consideration as to how to secure the best outcomes for the patient.

6) More generally, both NHS England and NHS Improvement have recognised the needs to obtain more data on discharge flows and processes. NHS England has also established a new cross-agency work stream on Community Services and Hospital Discharge (CSHD), within the umbrella of the Urgent and Emergency Care Review. The work stream will identify and deliver a series of interventions which will achieve system-wide transformation of community services, supporting timely discharge from hospital, reducing the strain on the acute sector, and achieving the efficiency gains set out in the Five Year Forward View. Activity will include exploring the development of new metrics to understand the true impact of delays to discharge and patient flow, and to allow regular monitoring of and action in response to national trends in performance. The delayed transfers of care metric could be complemented with other metrics, for example on stranded patients, discharge to usual place of residence and length of stay.

7) NHS England launched a local discharge Commissioning for Quality and Innovation (CQUIN) payment in 2016 using the 'stranded patient' metric. The CQUIN indicator reflects a medium-term intention to move beyond the Delayed Transfers of Care measure and to improve the way systems gather intelligence on patient flow and transfers of care.

(2) Time of discharge

We agree with the Alzheimer's Society that night discharges are potentially dangerous for patients, and detrimental to their carers and relatives. Whilst we are aware that an outright ban on night discharges might have unintended consequences, the Secretary of State for Health must set out, in the Government's response to this report, how he intends to ensure that only those who want to be are discharged between 11pm and 6am (Paragraph 22)

8) The timing and arrangements for hospital discharge are a local matter and subject to clinical decision making, and as such, it would not be appropriate, or practical for Government to interfere in these arrangements. However, we would expect that the safety and wellbeing of patients be given the fullest consideration as part of the process. Clearly, for some patients, discharge between 11pm and 6am will not be appropriate. This includes, but is not limited to, those with a diagnosis of Alzheimer's or dementia, and we would expect that these patients are not discharged until appropriate arrangements are put in place. This is particularly the case for people who live alone and/or require homecare support.

9) However, for those patients who are fit, able, and ready to leave and wish to do so, it is important trusts are able to discharge them accordingly. For patients who are frail and elderly, the comprehensive geriatric assessment tool can be used to assess the medical, psychological and functional capabilities of a frail elderly person as well as social circumstances.

10) For people who have been kept in over-night in order to receive further observation, hospital multidisciplinary teams, consisting of therapists, nurses, social workers and support workers, should work together to assess and plan for that patient, to support them to their place of residence as soon as is safely possible. In many areas the voluntary sector is also commissioned to support less complex discharges home.

(3) Delayed Transfers of Care

The PAC, in its July 2016 report, concludes that there is a poor understanding of “both the scale and cost of the problem of delays in discharging older patients from hospital”. The PAC recommends that NHS England develop measures for improving its understanding of these issues. We strongly agree with their recommendation (Paragraph 25).

11) NHS England agreed with the recommendation of the Public Accounts Committee (PAC). The Department, NHS England and NHS Improvement recognise the importance of understanding the costs and benefits that would result from reducing the number of delayed discharges from hospitals.

12) NHS England is leading activity to embed a minimum community dataset which will allow an accurate understanding of levels of activity within community health services from autumn 2017. This will help enable a robust picture of costs and implications of delayed discharges to emerge.

13) As mentioned in our response to recommendation 1, NHS England has also established a new cross-agency work stream on CSHD which is exploring the development of new metrics to understand the impact of delays to discharge and patient flow, allowing regular monitoring of national trends in performance. The local discharge CQUIN will also improve the way systems gather intelligence on patient flow and transfers of care.

(4) Improving Communication in discharge

We regard the failure of hospitals to involve carers and relatives in decisions to discharge patients, and even to inform them of these decisions, as maladministration and unacceptable. The Secretary of State for Health and NHS England must set out, in the Government's response to this report, how this issue will be analysed and assessed and what steps will be taken to promote improved communication with relatives and carers by hospital staff. (Paragraph 30)

14) Appropriate communication, not just with patients, but with relatives and carers is a key principle of NHS care as defined in the NHS Constitution. The communication of NHS Staff continues to be monitored through the annual Adult Inpatient Survey, published by the Care Quality Commission, which reflects the view of over 80,000 patients. The latest survey report for 2015, published in June 2016, included new ‘integration questions’, looked at how services work together when planning discharge, alongside existing questions on discharge assessment and planning generally. Results included:

- 85% of people felt they had been involved in decisions about their discharge from hospital (56% yes definitely, 29% to some extent). Overall up 1% from the previous year.
- 88% of people said they were given notice about when they were going to be discharged (57% yes definitely, 31% to some extent). Overall up 1% from the previous year.
- 71% said doctors or nurses gave their family or someone close to them information they needed to help care for them (48% yes definitely, 23% to some extent). Overall down 3% from the previous year.

15) The survey results, which are published nationally and at trust level, and benchmarked between services, help drive improvement locally. The CQC uses the results from the survey in the regulation, monitoring and inspection of NHS acute and NHS foundation trusts in England. Clearly, where performance has dipped in comparison to the previous year, we would expect Trusts to work hard to improve patient care.

16) NHS Improvement is leading a national programme of work to support organisations in improving the communication and management of information around the discharge process building on successful local and national initiatives already in place. The programme is run in partnership with the regional [Patient Safety Collaboratives](#) and Academic Health Science Networks and aims to develop a best practice online resource for all organisations concerned with discharge from secondary care settings.

17) In March 2016, NHS England and its system partners published a *Quick Guide: Supporting people's choices to avoid long hospital stays*. This includes clear guidance about the process of discharge and the importance of involving relatives and carers in discharge arrangements. As part of the national A&E Improvement Plan programme, led by NHS England and NHS Improvement, all trusts are required to implement the discharge policy guidance within this Quick Guide. An independent evaluation of this Quick Guide is also being undertaken over the next few months by the older people's charity, Independent Age.

18) Finally, in December 2015, the National Institute for Health and Care Excellence published *Transition between inpatient hospital settings and community or care home settings for adults with social care needs*. The guideline covers the transition between inpatient hospital settings and community or care homes for adults with social care needs. It aims to improve people's experience of admission to, and discharge from, hospital by better co-ordination of health and social care services. The guideline makes it clear that:

- a single health or social care practitioner should be responsible for coordinating a person's discharge from hospital; and
- the discharge coordinator is the central point of contact for health and social care practitioners, the person and their family during discharge planning.

19) NICE is also developing a Quality Standard based on the guideline, which will set out the makers of high quality discharge care to help commissioners, providers drive up standards and compare services. The Quality Standard will be published shortly.

(5) Reporting back to the PACAC on uptake of best practice

It is clear from the evidence presented to this Committee, and from the findings of the PAC's inquiry into delayed transfers of care, that best practice guidance on patient discharge is not consistently implemented across healthcare providers. Tackling this variation in discharge processes is key to producing greater consistency in outcomes. We welcome and strongly support the recommendation of the PAC that NHS England and NHS Improvement report back to that committee by January 2017 on the steps they have taken to increase the pace of good practice adoption. (Paragraph 34)

20) NHS England and NHS Improvement agreed with the recommendation of the PAC. Discharge is one of the five key areas covered by the NHS England and NHS Improvement-

led A&E Improvement Plan for 2016–17. All systems have received Rapid Improvement Guidance to support the implementation of a number of best practice models, such as those incorporating intermediate care, selected on the basis of available evidence and expert advice.

21) NHS England has developed a baseline assessment tool to establish what progress local areas have already made on implementing the initiatives contained within the A&E Improvement Plan. Local plans will be drawn up and specific support allocated on the basis of these results. NHS England has also published a series of quick guides to support local health and care systems. These guides provide practical tips, case studies and links to useful documents to increase the pace of implementation. One example would be [Home First: Discharge to Assess](#), which provides practical tips, case studies and links to useful documents to increase the pace of adoption. This includes guidance on mapping out intermediate capacity, funding options, and good examples of local systems effectively using the intermediate care layer to improve hospital flow and discharge outcomes.

22) Local systems have been segmented into cohorts based on local performance and challenges. Providers with serious challenges will be subject to the highest level of performance management, including: exposure to national spotlight and intervention; potential removal of leadership; and potential changes to Trust organisation.

23) Providers will also have access to a range of improvement measures, including dedicated planning and system leadership review as well as intensive Emergency Care Improvement Programme (ECIP) support. ECIP is a clinically led improvement programme, originally commissioned in 2015 to work with the 28 most challenged systems. The Programme has since been expanded in 2016–17 to cover 40 systems. ECIP uses national experts in urgent and emergency care along with quality improvement techniques to help local systems improve the care provided to patients.

Barriers to Best Practice Implementation

(6) Reporting of patient safety concerns/whistleblowing

We agree with the Local Government Association that strong leadership and engagement with staff is needed to support staff who are operating under significant organisational constraints. We are deeply concerned that hospital staff may be put in positions where they feel pressured to discharge patients before it is safe or appropriate to do so. We believe that it is the responsibility of hospital leadership to communicate to staff that organisational pressures should never take priority over person-centred care. Leaders should also ensure there are clear mechanisms for staff to raise concerns about unsafe discharge with hospital leadership. This can only be achieved with high levels of trust and openness between leadership and staff and this must be understood not just by the leadership of hospitals and social services, but by NHS Improvement too. (Paragraph 39)

24) We agree that staff should be able to raise concerns without fear of reprisals. Since the publication of *Freedom to Speak Up* (a review of NHS whistleblowing by Sir Robert Francis, published in February 2015), NHS Improvement has been working to improve the experience of whistleblowing in the NHS, to normalise it, and demonstrate that whistleblowing is a positive characteristic in an employee. This in turn should promote more openness about mistakes and associated learning.

25) On 1 April 2016, NHS Improvement and NHS England published *Freedom to speak up: raising concerns (whistleblowing) policy for the NHS*, to be adopted as a minimum standard by all trusts by 31 March 2017. This provides for a range of ways for staff to report their concerns. Since 1 October 2016, all trusts should have their own Freedom to Speak Up Guardians to support staff to raise concerns, and there is a National Freedom to Speak Up' Guardian, Henrietta Hughes, to support guardians in trusts.

(7) NHS England's work to support integrated care models

A lack of integrated working between health and social care presents a longstanding, persistent barrier to coordinated, safe and timely patient discharge. We fully endorse the recommendation of the PAC, aimed at establishing good practice models for improving integrated working across local health and social care systems. We look forward to NHS England's response to the PAC on what steps have been taken to increase the pace of adoption of such care models. (Paragraph 43)

26) NHS England agreed with the recommendation of PAC and it is supporting local integration of health and social care in a number of ways. The Better Care Support Team (BCST) is a partnership between NHS England, the Local Government Association (LGA), the Department of Communities and Local Government and the Department of Health to support the successful delivery of the Better Care Fund (BCF). Working with local areas, the BCST supports the development and delivery of their BCF plans to accelerate the pace and progress of integration.

27) The BCF Policy Framework for 2017–18 and 2018–19, published jointly by the Departments with input from the BCST, will require local partners to agree a joint plan which is supported by a pooled fund and meets a set of national conditions for every local area. As part of BCF planning, local areas will consider how they achieve integration of health and social care by 2020.

28) The New Care Models programme and the *Five Year Forward View* partners are working together to create the right environment for the wider adoption of new care models. One key tool for sharing good practice and enabling widespread adoption is the publication of frameworks describing the core components and essential ingredients of the new care models, and how to develop them. These frameworks will enable new sites to understand and work towards the implementation of fully mature models. Funding for existing vanguards and new sites will be available from a dedicated new care models funding stream from 2017–18.

29) The Department has worked with the local government sector to implement a culture of Sector-led Improvement. This is based on the principles that Councils are primarily accountable to local communities rather than Ministers; that they are responsible for their own performance and improvement; and that Councils are jointly responsible for the performance of the sector as a whole. Under the principles of Sector-led Improvement, the Department funds the LGA to deliver the Care and Health Improvement Programme (CHIP). At the highest level, the objectives of the 2016–17 programme are to help fulfil the Department's system stewardship role by managing risk in the adult social care system and to support local health and care systems to improve outcomes and services.

National responsibilities for improving discharge

(8) Establishing clear objectives for the discharge programme board

We welcome the establishment of the Discharge Programme Board, which will bring together national health and social care organisations to improve patient discharge. The Secretary of State for Health must establish by March 2017 a clear set of objectives for the Discharge Programme Board, together with success measures and timelines against which the progress of the Board in improving patient discharge can be measured. (Paragraph 46)

30) For this winter 2016–17, NHS England's CSHD work stream (see recommendation 1) will develop guidance to support community health services' role in avoiding hospital admissions and supporting discharge, as well as targeted support for areas to implement the 6 discharge requirements within the A&E Improvement Plan.

31) Going forward from winter, into 2017–18 and beyond, the work stream with focus on community health services commissioning standards, hospital discharge guidance and coordination of support packages, identifying measures for NHS Continuing healthcare, and reviewing the community health services workforce and labour market.

32) The Department led Discharge Programme Board will now focus on maintaining strategic oversight of delayed discharge issues and feed into the work of the Department's Arm's Length Bodies, including the discharge and flow elements of the national A&E Improvement Plan and the work of the CSHD Steering Group.

(9) Better Care Fund new homes bonus

We are concerned to learn that a significant proportion of the Better Care Fund's current funding is reliant on savings from the New Homes Bonus. This seems to PACAC to be an extraordinary way to fund essential public services. The Government must explain what is happening in parts of the country where these funds do not materialise. (Paragraph 49)

33) The Spending Review 2015 fixed the funding envelope for a reformed New Homes Bonus that was designed to sharpen the incentives for new housing. Reforming the way the New Homes Bonus rewarded housing growth reduced the overall cost of the Bonus. The Spending Review 2015 also set the budget for the improved BCF; £105m in 2017–18, £825m in 2018–19 and £1.5bn in 2019–20. The reduced budget for the New Homes Bonus provided the majority of this funding but it was supplemented by £825m of additional funding. The New Homes Bonus reforms include the introduction of a national baseline which Government has said it will vary depending on housing growth, to ensure that the New Homes Bonus budget remains within the Spending Review envelope. The availability of this money for the Improved BCF is not reliant on the performance of local government generally or individual councils to release savings. The Government has consulted on the distribution of the improved BCF as a part of the local government finance settlement 2017 - 2018 technical consultation and will be publishing its response shortly.

34) Reforms to the New Homes Bonus will release important funding for adult social care, recognising the demographic changes of an aging population, as well as a growing

population. Responding to calls for additional funding for social care to address growing pressures, the Government also announced on 15 December 2016 the intention to retain a further £240 million within the local government finance settlement to fund adult social care through the Adult Social Care Support Grant, funded by the reforms to the New Homes Bonus. This money will be available in 2017–18 and distributed using the social care Relative Needs Formula.

(10) Funding plans for social care

We are concerned that the current funding plans for adult social care will not adequately tackle the long-standing social care funding gap. We ask the Government to bring forward a comprehensive solution to health and social care funding that reflects a long-term, sufficient, sustainable, integrated approach to adult social care funding. Recognising that change will take time, but that the status quo is not adequate, the Government should set out a route map for how the new funding arrangements will be implemented, by March 2017. (Paragraph 53)

35) Social care is a key priority for this Government. This is why, against the context of tough public sector finances, we have taken steps to protect social care services. Local authorities have been given access to £3.5 billion of new support for social care by 2019/20. This is mostly through the introduction of a new Social Care Precept. At Spending Review 2015, it was estimated that this could raise up to £2 billion a year for social care by 2019/20. Next year, local authorities will be able to raise the precept earlier - by up to 3%, and 3% the year after (2018/19), but by no more than 6% over the next three years. This could raise £200m in additional funding for adult social care in 2017/18 and over £400m in 2018/19. From April 2017, the Spending Review makes available further social care funds for local government, rising to £1.5 billion by 2019/20, to be included in the BCF. Taken together, the new precept and additional BCF contribution mean local Government has access to the funding it needs to increase social care spending in real terms by the end of the Parliament.

36) We recognise that councils will need to continue to find savings and efficiencies to support fiscal consolidation. However, many councils have risen to the challenge of achieving savings whilst setting balanced budgets, keeping council tax low and maintaining satisfaction in services. We continue to support councils to achieve efficiencies and are working with the LGA and the Association of Directors of Adult Social Services on this agenda. Ultimately, it is for local authorities to decide how to prioritise their spending based on local priorities and need.

(11) Fully integrated Health and Social Care

We welcome the Government's clear policy statement and vision for comprehensively integrated health and social care spending. We note however, that HM Treasury has yet to fully articulate how this vision will be achieved. We recommend that the Government sets out a clear plan for implementing this policy without delay, taking into consideration ongoing funding pressures in social care, which are yet to be adequately addressed. (Paragraph 55)

37) At the Spending Review 2015, the Government announced its commitment to integrating health and social care by 2020. The BCF has set the foundation, but we want to go further, faster to deliver joined up care. The overarching aims of the BCF are to keep people living independently at home, providing the support they need to prevent avoidable hospital admissions, and to return home as soon as possible, if hospital care is required. In 2015/16, many areas went beyond the BCF's minimum requirements, increasing its total value to £5.3 billion.

38) In addition to committing to the BCF's continuation up to 2019–20, the 2015 Spending Review made available, through the BCF, further social care funds for local government from 2017 (rising to £1.5 billion by 2019–20), as well as £500 million by 2019–20 for the Disabled Facilities Grant to fund around 85,000 home adaptations in 2019–20.

39) The ways local areas integrate will be different, and some parts of the country are already demonstrating different approaches that reflect models the Government supports. We are currently working with local areas to design the criteria and assurance process for graduating from the BCF. The *Integration and Better Care Fund Policy Framework for 2017–19*, due to be published early in the New Year, will set out the requirements for BCF plans and further detail on the graduation process.

(12) Role of the Healthcare Safety Integration Branch

Our predecessor committee's sixth report of the 2014–15 session, 'Investigating clinical incidents in the NHS', has resulted in the government establishing the Healthcare Safety Investigation Branch (HSIB). We expect this emerging body to play a major role in investigating serious incidents of unsafe discharge, to learn lessons from each case, and to ensure that learning is disseminated and implemented throughout the NHS. (Paragraph 57)

40) The Healthcare Safety Investigation Branch (HSIB) was established by the Secretary of State for Health in April 2016. It is tasked with carrying out independent safety investigations across the healthcare system in England, and will be operational from April 2017.

41) The purpose of the HSIB is to determine the causes of accidents and serious incidents, and to make safety recommendations intended to prevent recurrence and to improve safety across the healthcare system. It is not to apportion blame or liability. An Expert Advisory Group (EAG) was set up in August 2015 to advise the Department of Health and the Secretary of State on the scope, governance and operating model for the new body. On completion of the work of the EAG, directions for establishment of the HSIB were issued by the Secretary of State, and Mr Keith Conradi was appointed as the first Chief Investigator in June 2016

42) The HSIB has been established, for the time being, as an arm's length division of NHS Improvement. However, the directions and the intention are clear that the HSIB is to be independent in all matters relating to its investigative function, and is accountable to NHS Improvement only in respect of its funding and staffing. In respect of investigations, the Chief Investigator will report to the Secretary of State. There are inevitably a large number

of structural and administrative decisions and actions in setting up the HSIB and these include the method by which subjects for investigation will be determined as the HSIB will have limited capacity to undertake its own investigations.

I hope this reply reassures you of the Government's Commitment to ensuring that health and care organisations work closely and effectively to deliver services that offer the greatest value to patients across the care pathway, including in discharge care.