HSIB

HEALTHCARE SAFETY INVESTIGATION BRANCH

Investigation Process

Sandy Lewis – Director of Maternity Investigation
Prof James Walker – Clinical Director Maternity Investigations

Background and Overview;

HSIB

- The Healthcare Safety Investigation Branch (HSIB) was established by an expert advisory group following recommendations from government inquiry into clinical incident investigations

- Operational since **1 April 2017**
- Hosted by NHSI & funded by DH but operates independently
- Investigation team includes people with a professional investigation background in health, aviation and the military
- Led by Chief Investigator Keith Conradi – former head of AAIB

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HSIB Maternity Investigations

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Background

- In November 2017, the Secretary of State for Health announced a new maternity safety strategy – and directed HSIB to conduct **1000** independent safety investigations
- The investigation element is part of an national strategy to improve maternity safety
- A maternity implementation team was established to develop the approach, the methodology, and recruit investigation teams
- The programme started in **April 2018**, with full national coverage expected by **April 2019**

Why is HSIB carrying out these investigations ?

We have a unique position as national and independent investigator to:

- bring a standardised approach to maternity investigations without attributing blame or liability
- work with families to make sure we understand, from their perspective, what has happened
- work with and support local teams to improve safety investigations
- bring together the findings from over 1000 reports to identify themes and draw out **wider system learning.**

Investigation Criteria

HSIB will undertake maternity investigations which meet the 'Each Baby Counts' criteria and a defined criteria for maternal deaths.

Babies whose outcome was the result of congenital anomalies will be excluded.

The defined criteria is eligible babies which include all term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

- **Intrapartum stillbirth**:
  where the baby was thought to be alive at the start of labour but was born with no signs of life
- **Early neonatal death**:
  when the baby died within the first week of life (0-6) days of any cause

Investigation Criteria

- **Severe brain injury** diagnosed in the first 7 days of life, when the baby
  Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE)
  OR
  Was therapeutically cooled (active cooling only)
  OR
  Had decreased central tone AND was comatose AND had seizures of any kind

NB The definition of labour for Each Baby Counts includes:

- any labour diagnosed by a health professional, including the latent phase of labour
- when the woman called the unit to report any concerns of being in labour e.g.(but not limited to) abdominal pains, contractions or suspected ruptured membranes
- induction of labour
- when the baby was thought to be alive following suspected or confirmed pre-labour rupture of membranes

HSIB Maternity Team Structure

Sandy Lewis
Director of Maternity Investigations

Prof James Walker
Clinical Director

Lisa Marshall
Head of Maternity Investigations (South)

Katherine Hawes
Head of Maternity Investigations (North)

- Team Leader (SE) Amanda Morgan
- Team Leader (LE) Jude Piper
- Team Leader (SC) Clara Cooper
- Team Leader (LC) Anne Tasker
- Team Leader (SW) Maria Patterson
- Team Leader(LW) Emma Kenny
- Team Leader (M&EE) Elaine Hide
- Team Leader (NE) Ruth Cartwright
- Team Leader (M&E CN) Ethel Oldfield
- Team Leader (NN) Nicola Horrocks
- Team Leader (M&E CS) Lorna Bass
- Team Leader (NC) Cara Taylor
- Team Leader (M&E W) Katherine Leach
- Team Leader (NW) Ceri Morris- Williams

- Clinical Advisor Sonia Barnfield
- Clinical Advisor Louise Page
- Clinical Advisor Peter Thompson
- Clinical Advisor Chandrima Biswas

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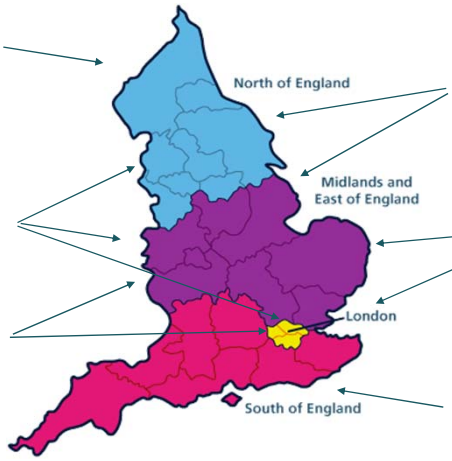
Roll Out Progress

December 2018
- 2x Northern Teams
- Live with 78 Trusts

March 2019
- 1x Northern Team
- 1x Midlands & East
- 1x London
- Live with 130 Trusts

November 2018
- 1x Midlands & East
- 1x London
- Live with 61 Trusts



February 2019
- 1x Midlands & East Team
- 1x North
- Live with 104 Trusts

October 2018
- 1x Midlands & East
- 1x London
- Live with 48 Trusts

Currently live with 104 Trusts

July 2018
- 3x Southern Teams
- Live with 34 Trusts

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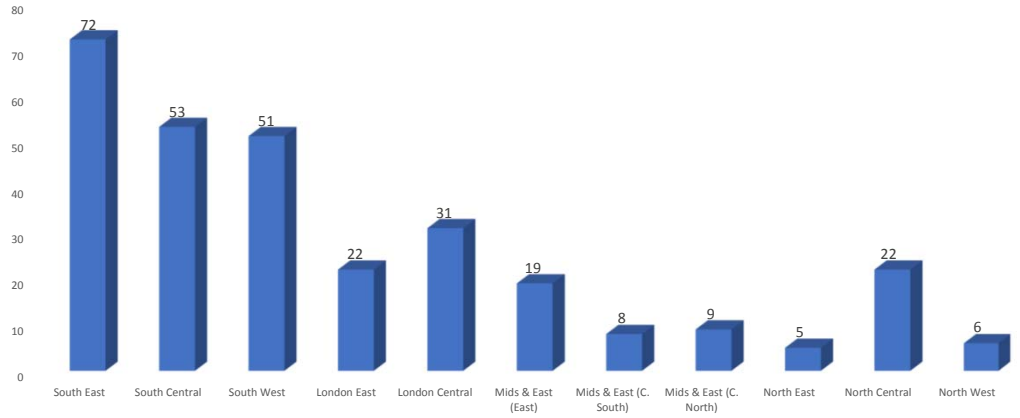
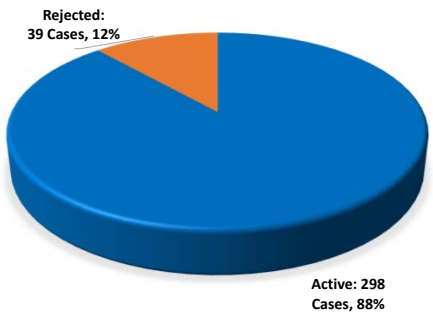
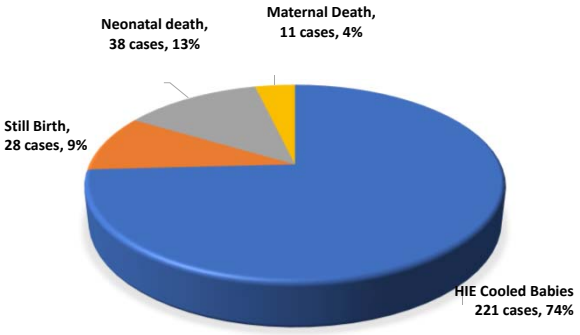
Active cases per region 22/02/2019



Investigations 22/02/2019

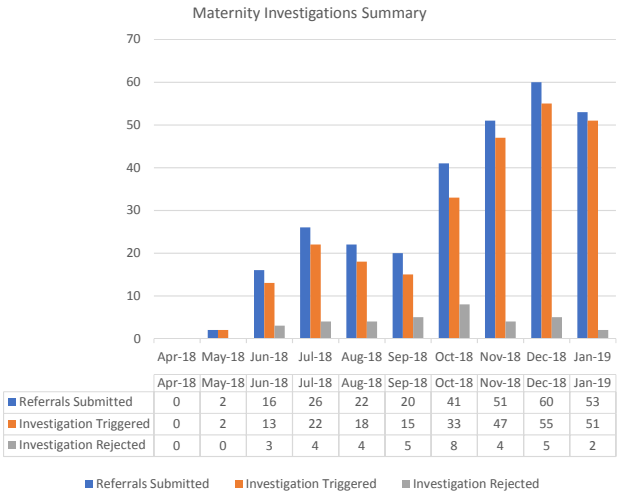




Currently 298 Live Investigations

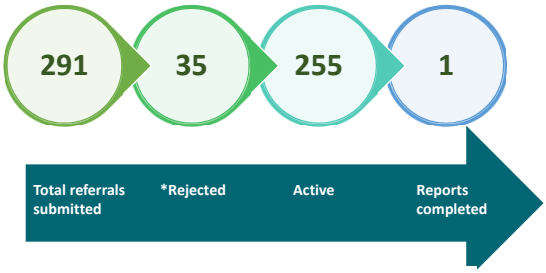
MATERNITY INVESTIGATIONS

launched from April to 31 January 2019



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
Referrals Submitted	0	2	16	26	22	20	41	51	60	53
Investigation Triggered	0	2	13	22	18	15	33	47	55	51
Investigation Rejected	0	0	3	4	4	5	8	4	5	2

Total number of Maternity Investigations



*35 = 12 did not meet HSIB criteria, 12 duplicated (IT), 2 congenital abnormalities, 2 Sudden Infant Death, 7 no consent

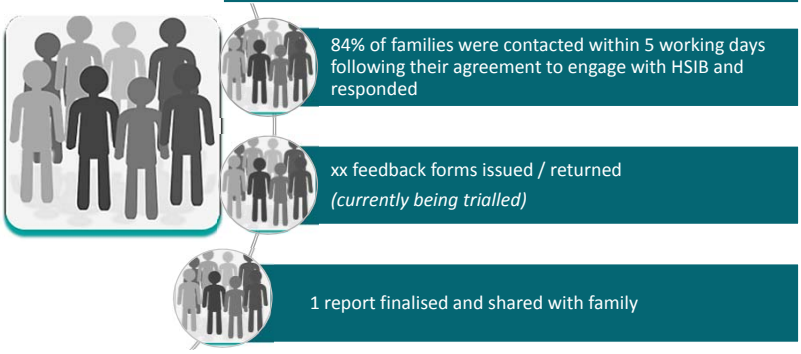
Slight variance from previous months figures, due to delays in trust completing referrals (on-going IT development)

MATERNITY FAMILY ENGAGEMENT

Equality and Diversity data is being collected to integrate with the data available for engagement

97% of families (who have been contacted) have agreed to engage

3% of families (who have been contacted) have declined to engage



249 families invited to engage of which 7 families declined (these cases are therefore rejected)*. 13 families waiting on confirmation from Trust. 1 family declined direct contact. (=249-7+14=256)

84% of families were contacted within 5 working days following their agreement to engage with HSIB and responded

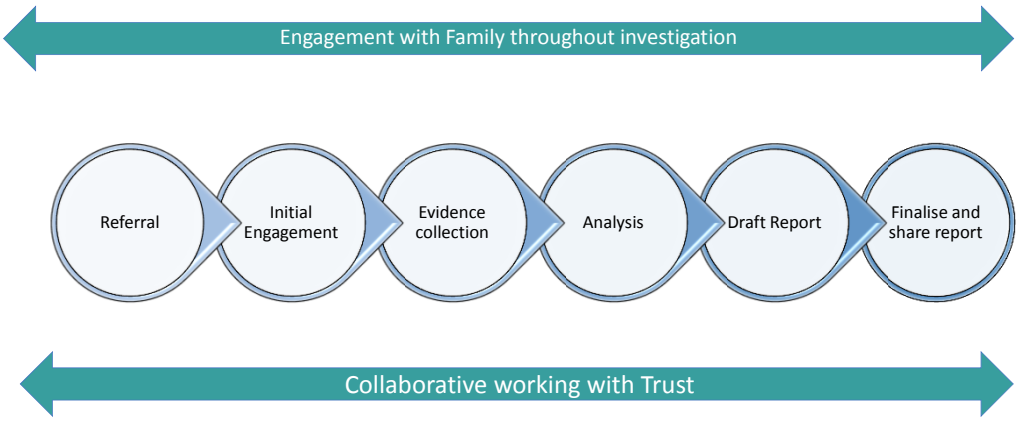
xx feedback forms issued / returned

(currently being trialled)

1 report finalised and shared with family

*Trusts refer all cases to HSIB which meet the Each Baby Counts criteria. Families involved in these cases will then be approached to give their consent for HSIB to conduct an investigation and engage in the investigation process. If a family refuse to give their consent, an investigation cannot proceed and the case therefore must be rejected

Investigation Approach



Trust Responsibilities

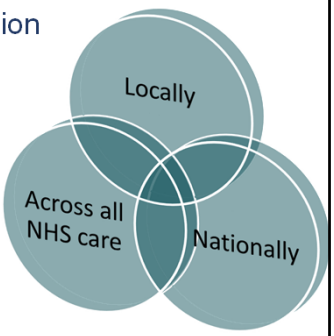
- Some of these cases will be classified as Serious Incidents (SI). HSIB investigations will replace the Trust SI.
- Trusts will continue to investigate SI maternity events that are outside the specified criteria.
- In all cases Trusts will continue to have the responsibility of completing **STEIS**, the **72 hour report, Duty of Candour**.
- The perinatal mortality review tool (PMRT) will be completed jointly with the Trust and HSIB on completion of the maternity investigation.

Investigation Information

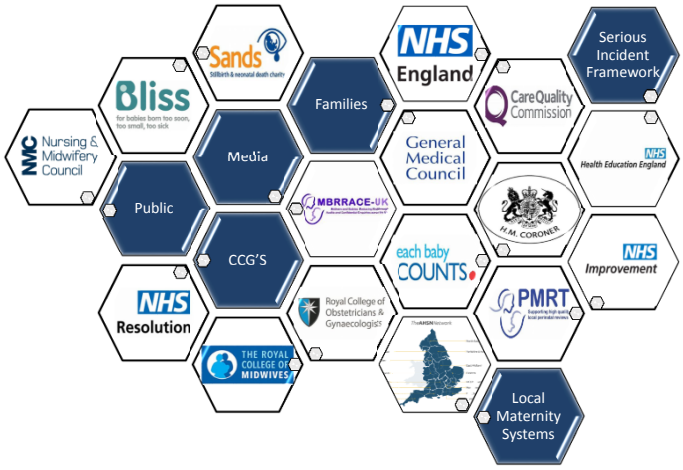
- HSIB are legally responsible for carrying out and completing all investigation that meet our criteria.
- Each Trust and Commissioner will be informed what date they will go live with HSIB
- The HSIB investigation replaces the investigation originally done by the Trust
- The HSIB should be the only investigation carried out and this will be done in collaboration with the Trust and the family
- HSIB is not bound by the SI framework we are required to: Complete investigations within a reasonable time frame, not exceeding 6 months
- CCG's need to place extensions on cases referred to HSIB
- If there are any concerns the CCG's can contact us directly to understand how the investigation is progressing

Recommendations and Shared Learning

- HSIB will share with Trusts safety concerns they identify throughout the investigation
- Share learning from other investigations and Trusts to support changes in practice
- Feedback will be provided from initial findings of the investigation
- HSIB will work with Trusts to support recommendations being applicable in the clinical environment
- We will analyse individual report recommendations and draw out wider themes
- We will share recommendations with regulators and professional bodies who can initiate change at a national level.



Collaborative Approach



Questions ?

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