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NHS

Safety Culture in Focus - Issue 10

Louise Page, Deputy Director of the Maternity Investigation Programme & Amanda Morgan, Regional Lead for Maternity Investigations Programme (South) joined us from the Healthcare Safety Investigation Branch (HSIB).

Amanda provided an overview of the HSIB Investigation Programmes highlighting the differences between the National Investigations Programme and the Maternity Investigations Programme:

National Investigations Programme	Maternity Investigations Programme
2016 Directions – core purpose of HSIB	**2018** Directions – additional specific programme
Diverse range of healthcare services and safety risks	Explicit focus on NHS Maternity Services in England
Criteria: we decide • Scale of risk and harm • Potential for learning to prevent future harm • Impact on individuals and public confidence in the healthcare system	**Criteria: set for us** • RCOG Each Baby Counts programme • Direct maternal deaths • Indirect maternal deaths while pregnant or within 42 days of giving birth
Up to **30** investigations a year	Circa **1000** investigations a year
Do not replace local investigations	Replaces the local investigation
Recommendations made to healthcare & beyond	Recommendations made only to the Trust
Reports published on HSIB website	Reports belong to the family and the Trust

HSIB Myth Busting

- Trusts are expected to complete Duty of Candour, 72 hour review & obtain consent for contact from HSIB from mother/family
- HSIB encourage Trusts to maintain contact with mother / family
- Do not recommend the Trust undertake a parallel investigation
- HSIB do not use staff statements as reutine investigation evidence
- Staff can request to receive an audio copy of their interview
- Any HSIB investigation material can be requested as part of judicial review
- Over 90% of HSIB investigations are completed within 6 months

Trusts are also asked to:

- Once consent for record sharing received, A Trust is requested to upload the medical records for the mother and baby in a structured format, once consent for record sharing is received.
- Help the HSIB team to contact staff in order to arrange interviews in a timely manner.
- Share the draft report with members of staff interviewed as the investigation comes to a close.
- Complete the factual accuracy review of the report in a timely way and encourage staff to also check the report.
- Participate in a tripartite meeting when requested.
- Support multi-disciplinary attendance at HSIB Quality Review Meeting (please note that Board Safety Champions are welcome to attend these meetings).
- Provide feedback to the HSIB on the organisations and the staffs experience of the investigation to help HSIB learning and improvement.

HSIB from a families perspective:

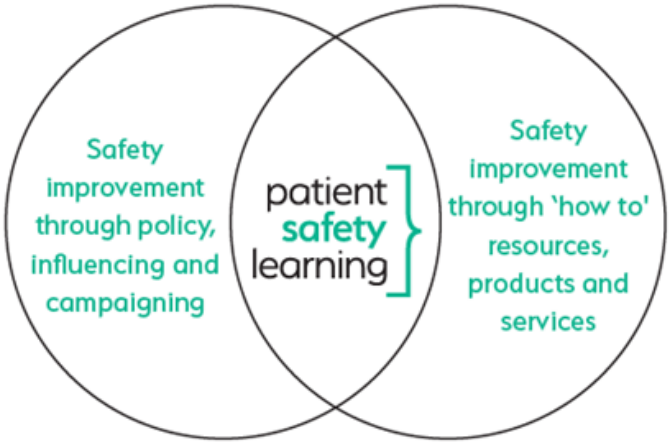
"We would like to reiterate how grateful we are.

The report has helped us to move forward in the grieving process and to feel that [our] baby's death has been given the due care, attention and diligence it deserves, not only uncovering the facts, but also helping to prevent any future incidents.

This provides us with some comfort and adds even more meaning to such a short precious life. These reports are invaluable and we would be in a totally different place without it."

Helen Hughes, CEO of Patient Safety Learning, joined us to discuss 'systems and organisational patient safety standards'.

Patient Safety Learning (PSL) is an independent charity for patient safety.



"Organisationally we often think that deference to expertise is to your Directors, or NEDs, or your chair, or your senior leaders and actually the expertise can often be coming directly from your frontline staff so knowing who are the right people to engage with."

Helen Hughes, CEO - Patient Safety Learning

Organisational Patient Safety Standards are valuable to assess how well we are doing in achieving our broader aims and help us deliver our safety improvement plans. Whilst these standards are yet to be launched, they are being tested with organisations. Contact Patient Safety Learning to hear more about the standards.

Leadership and governance

1. Patient safety is a core purpose
2. Patient safety is embedded in governance
3. Organisation has a patient safety plan
4. New services are designed for safety
5. System leadership
6. Organisational leadership for patient safety

Culture

7. Patient safety culture tackles blame and fear
8. Promotes patient safety improvement
9. Role of HR

Shared learning

10. Learning goals for improving patient safety
11. Learning from near misses
12. Learning from investigations
13. Learning from feedback and complaints
14. Learning from others
15. Shares learning with others

Professionalisation of patient safety

16. All staff are suitably qualified and experienced
17. Specialist skills in patient safety and human factors

Patient engagement

18. Commitment to patient engagement
19. Organisational systems for engaging with patients
20. Patient engagement in their own care
21. Patient engagement if things go wrong
22. Patient engagement for safer care

Data and insight

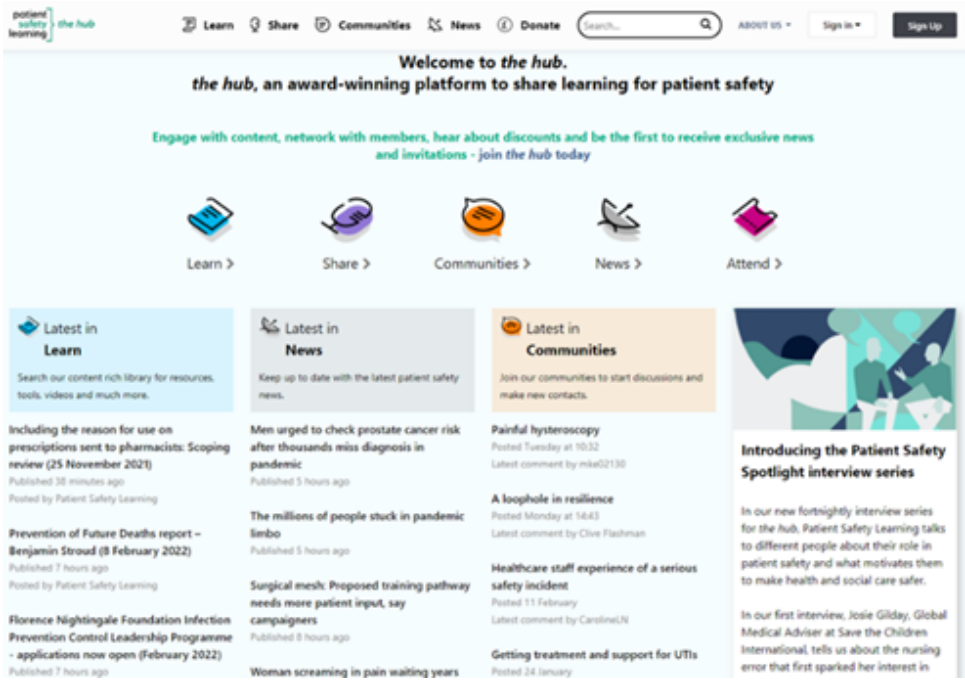
23. Metrics and data to measure and manage patient safety

Delivery of patient safety services

24. Services are delivered safely
25. Workforce planning
26. Workforce deployment

Patient Safety Learning Hub

- Free knowledge sharing platform
- Promoting patient safety good practice and policy
- 700k page views since launched from 205 countries
- Clinicians, patients, industry, policy makers



Resources

HSIB – National Learning Report - Giving families a voice

HSIB – Information for Trusts and staff

HSIB Maternity Team – What NHS Trust staff can expect from an HSIB investigation

NHS England – Supporting our NHS people

Patient Safety Learning

PSL – the Patient-Safe Future: A Blueprint for Action

Work-as-imagined and Work-as-done

The Safety Culture Programme for Maternity and Neonatal Board Safety Champions was produced in collaboration with the Advancing Quality Alliance (Aqua) and NHS England.

www.aqua.nhs.uk *www.england.nhs.uk*