Good practice in managing safety incidents

We had very clear feedback from our maternity workshop that providers and stakeholders want us to share more of the good practice we find on our inspections.

We analysed the inspection reports from the National maternity inspection programme and want to share the good practice we found in relation to managing safety incidents. It is not exhaustive. But we hope that services can use the examples and get in touch with the trusts if they wish to learn more.

Effective incident review processes

Norfolk and Norwich University Hospitals NHS Foundation Trust - Norfolk and Norwich University Hospital

> "The trust moved to the Patient Safety Incident Response Framework (PSIRF) on 1 September 2023 and leaders triaged all incidents daily and RAG (red, amber, green) rated them in alignment with PSIRF guidance. Any incidents that were of moderate or severe harm, required further information or met national priorities were presented by the divisional weekly incident group to discuss the appropriate response and identify any lessons learned. Cases were then escalated to the trust complex case review group, as required."

> "Leaders told us an incident report was completed following every massive obstetric haemorrhage greater than 1.5 litres, all 3rd and 4th degree vaginal tears and any unanticipated admissions of newborns to the Neonatal Intensive Care Unit. All incidents had a case review by the investigation lead. If there were care issues or moderate or severe harm formal duty of candour was always completed, and the mother/family were always provided with an immediate debrief. Managers investigated incidents thoroughly and applied the Duty of Candour, although it was not clear from reports if they involved women, birthing people and their families in related investigations."

Sharing and embedding learning

Lewisham and Greenwich NHS Trust - University Hospitals Lewisham

> "The service held **a weekly 'education bus' and quiz sessions in the maternity areas** and the governance teams focused on different themes each month. For example, the team were focused on managing fluid balance in August 2023. There was evidence that changes had been made following incidents investigations. Staff explained and gave examples of additional training, process, pathway, and policy implemented following a serious incident. Following a baby abduction incident which occurred last year, the trust had implemented a new baby abduction policy and employed security staff for the maternity wards to maintain patient safety. The service had also introduced 2 hourly security rounds and a sign in register to ensure oversight of everyone entering and exiting the maternity wards."

North West Anglia NHS Foundation Trust - Hinchingbrooke Hospital

> "The service had a 'learning from incidents' midwife who was responsible for sharing learning from incidents with staff. For example, the rate of women who had a post-partum haemorrhage (PPH) of 1,500 millilitres or more was higher than the national

> average and in the highest 25% of all organisations. Further education and training was introduced to make sure practice was embedded to reduce the incidence of PPH."

External peer review with a local trust

Leeds Teaching Hospitals NHS Trust - Leeds General Infirmary

> "The service had a weekly Perinatal Mortality Review tool (PMRT) meeting that was attended by a multidisciplinary team including the Women's CSU quality and safety team, consultants and midwives. There was an ongoing action tracker to monitor learning and improvements. Managers shared learning from PMRT meetings through the monthly 'sharing the learning' newsletter. The service had set up an external peer review process with a local trust of a similar size serving a similar community for PRMT."