Health Innovation East Midlands

Local change, national impact

East Midlands Patient Safety Collaborative (PSC) Progress Report

Q1-Q2 (2025-26)

November 2025

K Khan

INTRODUCTION

This report provides an overview of the PSC programmes (Managing Deterioration and Martha's Rule, Maternity and Neonatal (MatNeo) Programme, Medicines Safety and Safer Systems) across the East Midlands, their impacts and key achievements as well as national, regional or local feedback on progress.

ROLE OF THE HIEM TEAM

Health Innovation East Midlands (HIEM) has been a driving force behind patient safety improvements across the East Midlands, working with partners to embed continuous learning and deliver measurable impact.

FEEDBACK

Patient safety is a way of working here, and like a stick of rock you can see the patient safety agenda through all programmes - Head of Martha's Rule and Patient Safety Improvement Programmes.

Part of the Health Innovation Network
Local change, national impact

Accelerated Access Collaborative

Office for Life Sciences

NHS

Managing Deterioration and Martha's Rule Programme

Martha's Rule gives patients and their families the right to request an urgent review from a senior clinical team if they are worried about a worsening condition.

- Continuation of support across eight pilot sites and four phase two sites. 651 calls made across the Midlands (April- Sep 2025- see figure 1).
- The Health Innovation East Midlands/Health Innovation West Midlands data dashboard continues to be used as a tool for improvement.
- Facilitation of virtual communities of practice (COPs) continues alongside providing individual coaching to guide implementation efforts.
- Mapping review across all sites to help develop improvement goals and tailored support.
- Regular meetings with HIEM, Health Innovation West Midlands (HIWM), and East and West Midlands Critical Care and Paediatric Operational Delivery Networks (ODNs).

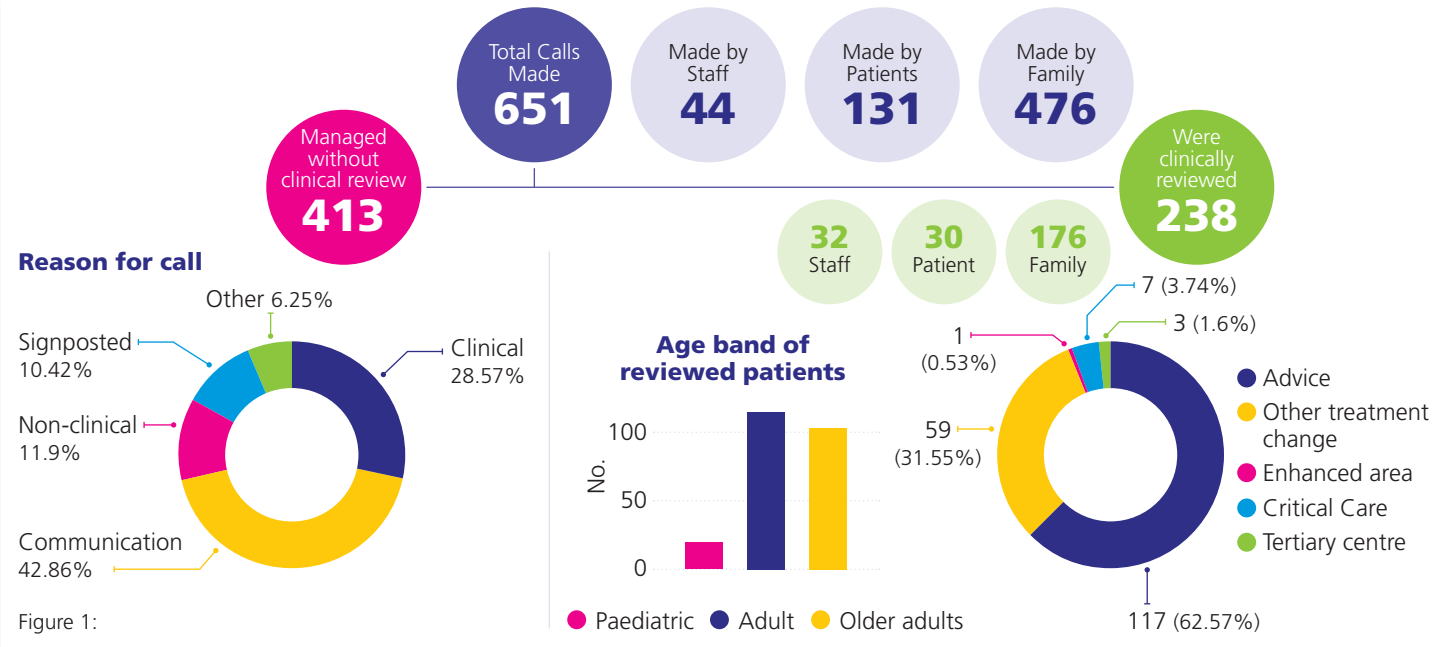


Figure 1:

Martha's Rule: Community Hospital Pilot

- Identification, onboarding of pilot sites and programme launch.
- Development of measurement for improvement plan including minimum data set, to assess programme impact.

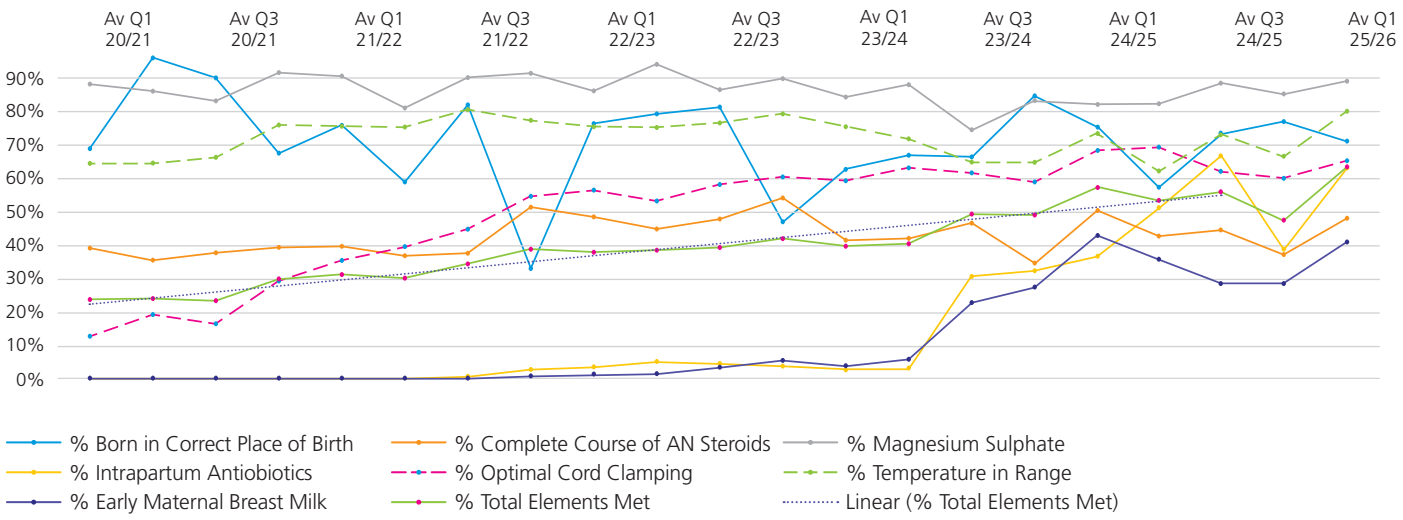
NATIONAL / LOCAL FEEDBACK

- Phase 2 sites feedback the implementation sessions are very useful, helpful and inclusive.
- Personal experiences and perspectives from Trusts are acknowledged, considered, and thoughtfully reflected upon, ensuring that feedback is grounded in real-world understanding and leads to more relevant and effective outcomes - Martha's Rule community of practice.

Maternity and Neonatal Optimisation and Stabilisation of the Preterm Infant (since April 2021)

- In the East Midlands babies receiving all elements for optimisation is now 63% (compared to 23% in 2020). This equals the national average of 63%.
- Action Learning Groups continue monthly with growing obstetric representation; 38 members across all 8 organisations. A live survey is evaluating ongoing impact and future development.
- Collaborative work with EMNODN is underway to address the poor uptake of Early Breast Milk in the East Midlands with a regional QI project launching in Q3.
- Co-led the Midlands Safer Maternity and Neonatal Conference, attended by 105 participants.
- EMPSC is developing a regional QI repository to be hosted on the NHS Futures platform.
- Collaboration with the Midlands Regional Consultant in Healthcare Public Health is identifying data-driven priorities to reduce inequalities in maternal and neonatal outcomes.
- Scoping underway with University Hospitals Leicester to explore a regional centre for Shirodkar Sutures to reduce preterm births and intrauterine transfers.

East Midlands MatNeo Optimisation Standards



Early Recognition and Management of Deterioration of Women and Babies

- A regional scoping tool was developed to assess implementation readiness and governance structures to inform future digital development planning, identify potential risks, and support the ongoing digital transition.
- A mapping exercise of digital and paper deterioration tools was completed in collaboration with the Midlands Maternity and Neonatal Digital Network.
- HIEM have worked with NHS England's Midlands Perinatal Team and Trust Leads from across all maternity services in the East and West Midlands to develop a standardised best practice approach to the management of Intrapartum Haemorrhage in the Midlands, with a new flow chart and resource tool expected to be launched in November 2025.

Perinatal Culture and Leadership Programme (PCLP)

- PCLP leads created an eight-session skills development programme to help train new culture coaches in the East Midlands.
- MOMENTS Train the Trainer programme delivered to three Trusts, training 25 colleagues, and with 34 delegates at the Midlands Professional Midwifery Advocate away day.
- Providing University Hospitals of Derby and Burton with leadership support for their Perinatal Leadership Team.
- Working with Nottingham University Hospitals to create a shared decision-making tool to support with intra-uterine transfers and contribute to babies being born in the right place.
- Regional perinatal meetings to define the PSC role, foster collaboration, identify coaching needs, and share information from Trusts who have noted improvements in perinatal working.

Avoiding Brain Injury in Childbirth (ABC)

New programme commenced in September 2025 which aims to reduce avoidable brain injury in childbirth by improving care in two high-risk areas:

- Recognising and responding to fetal deterioration during labour.
- Managing impacted fetal head during caesarean birth.

NATIONAL / LOCAL FEEDBACK

- It's really exciting to be working collaboratively with HIEM and the EMPSC to tackle this important topic, bringing the strength of both our networks together to improve outcomes for women and babies across the region - East Midlands ODN.
- Several optimisation measures for preterm infants are demonstrating significant improvement, with a number achieving the highest levels of improvement, demonstrating local outcomes of the work undertaken, and learning for other regions.
- The Culture Coach Skills sessions are absolutely fantastic and so needed - Lead PMA and Safety Champion.
- Using the MOMENTS tool to reflect on the way we work together has really helped bring new shared understanding and appreciation of how things can be interpreted differently by different team members - PMA Away Day.
- MOMENTS tool - I really like how it's a values-based tool which is different to other QI tools I've used - Patient Safety Midwife.

Medicines Safety Improvement Programme

- STOMP/STAMP working group relaunched with Terms of Reference and agenda co-developed.
- Cross-system collaboration initiated to streamline STOMP/STAMP templates.
- 12+ stakeholder interviews completed to support system mapping; ongoing engagement continues.
- Collaboration with Public Health and Local Authority to share programme information and identify engagement opportunities.
- New MedSIP webpage launched with standard and easy-read versions, reviewed by lived experience representatives.
- Clinician survey launched to assess confidence in structured medication reviews and annual health checks; ~40 responses received.

FEEDBACK

- Northamptonshire group noted the work "would not have been possible without HIEM's support," underscoring the value of collaboration.
- The system mapping process has been praised for its clarity and depth.

A joint project that encourages the use of more self-care skills to reduce the harm from opioids for people living with chronic non cancer pain was highly commended at the HSJ Patient Safety Awards. The project, which also involved Live Well With Pain (LWWP), Joined Up Care Derbyshire, University of Durham, St George's University Hospital & United Hospitals Birmingham was shortlisted in the Best Use of Integrated Care and Partnership Working in Patient Safety category.

Systems Safety

- The programme remains agile and responsive to the evolving healthcare landscape, with adaptations made in collaboration with NHS England's Patient Safety Implementation Leads.
- The programme has already engaged 14 of 15 Health Innovation Networks, 6 of 7 NHSE regional leads, 38 of 42 ICB PSIRF leads, and 20 providers across England.
- A national webinar on oversight and general practice was attended by 123 participants, receiving an average usefulness rating of 4.14 out of 5.
- A FUTURESNHS webpage has been launched to share progress and insights.

NATIONAL FEEDBACK

- "The current changing landscape has made the timing of this work even more important!! We want to be able to support ICBs to continue their important oversight role and this work will give us the insight we need to do that".
- "We know that oversight functions have a significant influence on the way activity to support safety is carried out. It has never been more important to understand the work that is carried out at system/ICB level and to think about how we build on this to enable supportive and compassionate oversight of patient safety response systems, so that we are united in our aim to learn and improve" - National programme leads.