Health Innovation East Midlands

Local change, national impact

East Midlands Patient Safety Collaborative (PSC) Progress Report

Q1-Q2 2026-2027

October 2026

K Khan

INTRODUCTION

This report provides an overview of the PSC programmes (Managing Deterioration and Martha's Rule, Maternity and Neonatal (MatNeo), 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) continues to play a pivotal role in advancing patient safety across the region, collaborating with partners to foster a culture of continuous learning and drive meaningful, measurable improvements in care.

FEEDBACK

"The team demonstrate programme maturity through a clear articulation of the QI methodology, supported by evidence of the impact and outcomes being achieved." (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

East Midlands Perinatal Deterioration Summit

We delivered a collaborative event designed to support organisations in improving the recognition and management of deterioration in pregnant and postnatal women, while strengthening patient safety across maternity services
Driving safer perinatal care: East Midlands Summit brings teams together to improve recognition and response to deterioration - Blog

Managing Deterioration and Martha's Rule Programme

- Provided ongoing support across eight phase-one sites and five phase-two sites.
- Continued to hold 1:1 coaching meetings with our sites.
- Delivered dedicated workshops focussed on sustaining Martha's Rule and used Quality Improvement and Emergency Department tools (NHS sustainability model) to do this.
- Onboarded (and continue to do so) maternity, neonatal and ED colleagues onto the programme, offering support and clarification of asks.
- Continued to hold Community of Practice sessions, co-led between us and the West Midlands for a Midlands-wide approach.
- Continued our relationship with the Operational Delivery Networks to give coordinated support to sites and organisations.
- Developed and tested a tool that will support sites to analyse Martha's Rule call data.

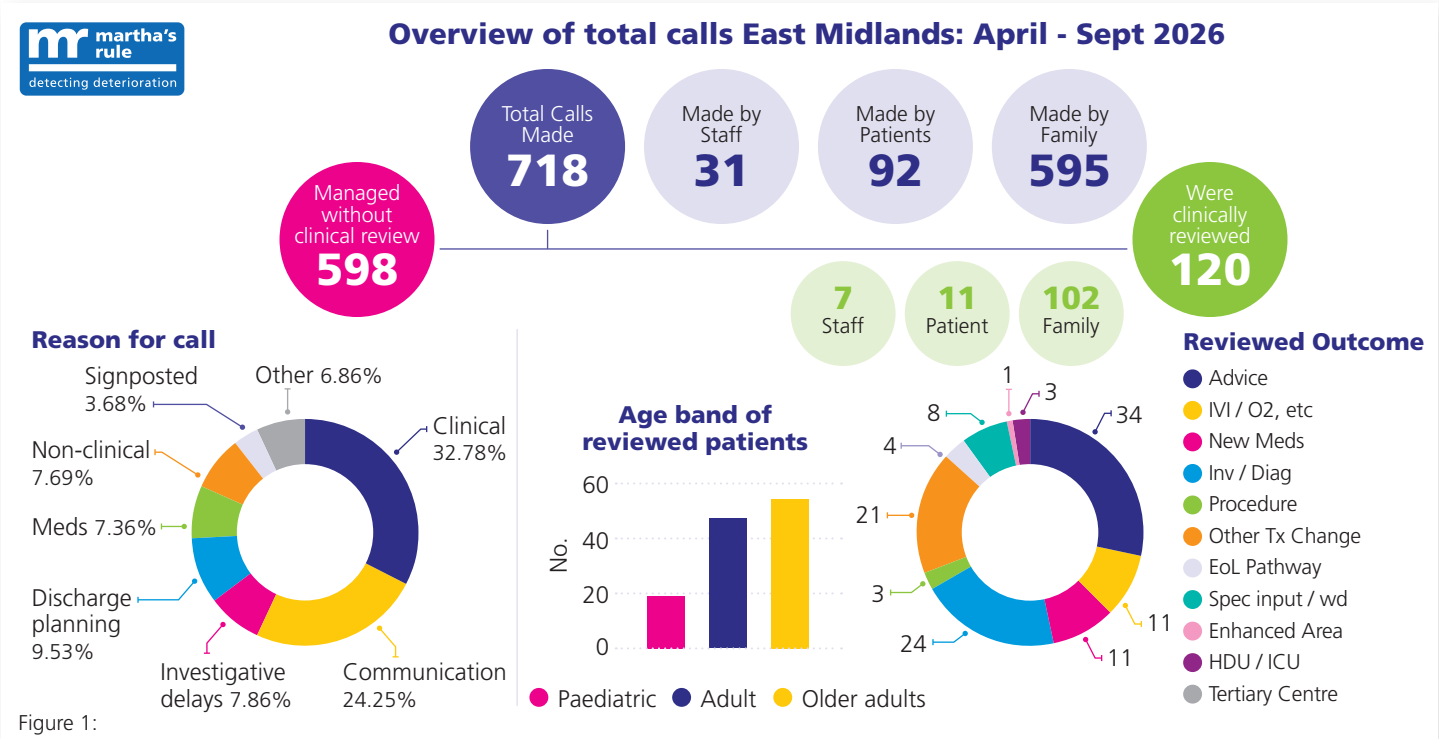
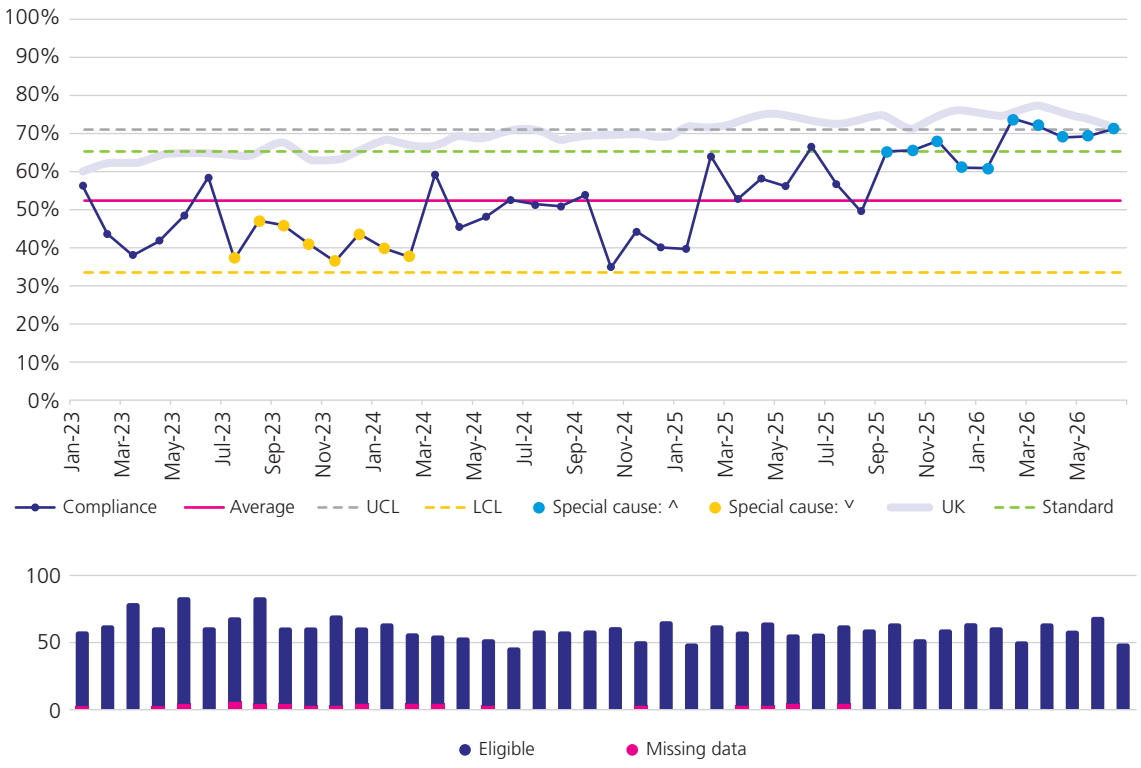


Figure 1:

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

- Increased network Day 2 Early Breast Milk (EBM) rates, with all units across East Midlands sitting above the National Neonatal Audit Programme (NNAP) standard of 65%. This is an increase from an average of 40% for the same period in 2025/26.
- Relaunched East Midlands Optimisation and Stabilisation Learning Collaborative in partnership with EM NODN. These monthly meetings focus on thematic deep dives of each optimisation element to strengthen QI capability and promote shared learning across the region.
- 4 out of 8 elements for optimisation are above national average (antenatal steroids, magnesium sulphate, intrapartum antibiotics, and thermoregulation).
- As of May 2026, EBM network average is closer to national average with Trusts predicted to continue increasing in compliance as project continues to Q3 2026. See Graph.

Mother's milk within first two days of life compliance for EMNODN (No: 2525)



NNAP: 65% of babies born <34/40 should receive mother's own milk in the first two days of life
N: babies born in period at <34/40, who received mother's own milk in first two days of life
D: babies born in period at <34/40

74%
babies received intrapartum antibiotic prophylaxis resulting in at least 11 lives saved from not being born with group b strep.

Between
7-10
lives saved due to receiving delayed cord clamping of 1 minute or more.

Between
11-15
lives saved due to receiving timely interventions and total optimisation.

Early Recognition and Management of Deterioration of Women and Babies

Maternity Early Warning Score (MEWS)

- Strengthened regional MEWS implementation through targeted guidance, FAQs and an implementation checklist, including support for digital transition.
- Monthly Action Learning Sets continue to address barriers, share best practice and accelerate regional implementation.
- Bespoke trust support is enabling consistent roll-out across maternity and outlier areas.

Newborn Early Warning Trigger and Track 2 (NEWTT2)

- Continued regional implementation and sustainability of NEWTT2, including support for trusts transitioning from paper to digital systems.
- Targeted data and QI support is helping trusts understand variation, identify improvement opportunities and sustain implementation.

Avoiding Brain Injury in Childbirth (ABC)

- Completed Intrapartum Fetal Deterioration (IFD) readiness assessments across all East Midlands trusts, identifying barriers and informing bespoke implementation plans, tailored to organisational need and readiness.
- Built regional Impacted Fetal Head (IFH) training capacity, with 46 staff completing Tier 2 training, creating a skilled faculty to support ongoing local delivery of Tier 1 training.
- Commenced IFH quality assurance visits to assess implementation and sustainability and share learning, with two completed and three further visits planned.

NATIONAL / LOCAL FEEDBACK

- "Since attending ABC IFH (Tier 1 training) I recognised at least three occasions where Impacted Fetal Head has occurred in theatre and verbally primed colleagues to be on standby to assist. Additionally, I recently had to give a vaginal push-up during a difficult case myself, and I felt confident doing this, thanks to the excellent training I received in the simulation." Obstetrician at UHDB.
- "Excellent collaborative work on the EBM project, showing increased breast milk rates." (Neonatal Consultant)
- "Great collaboration between digital / maternity and the wider team."
- "It was fantastic to network and ask lots of questions."

Medicines Safety Improvement Programme - Helping people with a learning disability, who are at risk of behaviour that challenges, avoid harm from psychotropic medicines

- Co-developing the first regional prescribing guidance for adults and children with learning disabilities who display behaviours that challenge, supporting safer prescribing across primary and secondary care.
- Embedding patient-facing Structured Medication Review resources in GP practices to strengthen understanding, preparation and shared decision-making.
- Developing a PCN-led multidisciplinary model for reviewing long-term psychotropic prescribing, supporting person-centred care and wider neighbourhood adoption.
- Mapping Positive Behavioural Support provision to identify gaps and opportunities for earlier access.

Together, these initiatives support safer prescribing, strengthen shared decision-making, and improve outcomes through a coordinated, system-wide approach to care.

In Northamptonshire and Leicestershire there are **over 850 people** on the learning disability register (excluding those on the Severe Mental Illness register) who are prescribed long-term antipsychotic medicine.

Since the MedSIP programme scoping phase started April 2024

35 fewer people prescribed these medicines

Estimated **13** people avoided severe harm

5% reduction in potentially inappropriate medicines

Systems Safety

- Developed a systematic and analytical approach designed to support East Midlands providers to map patient safety governance and the Patient Safety Incident Response Framework (PSIRF) learning infrastructure through:
  - Facilitated process mapping
  - Supported self-assessment of the development and adoption of system features that enable PSIRF
- Mapped common safety priorities across the East Midlands.
- Developed an offer to support Executive teams to turn PSIRF learning into meaningful improvement.

NATIONAL FEEDBACK

- "By strengthening system capability and oversight, the programme lays the foundations for long term efficiency, better patient safety and a culture that prioritises continuous improvement." (Lauren Mosley, Head of PSIRF Policy, NHSE)

Developing the infrastructure to enable safety improvement following systems-based learning responses across the NHS

- Understanding the existing infrastructure to support improvement
  - Identifying key leaders across the system
  - Mapping / describing current systems for supporting improvement to identify gaps and opportunities
- Developing the infrastructure to support improvement
  - Connecting people and building relationships
  - Supporting capacity development for the design, delivery and oversight of improvement
  - Supporting improvement focused planning activity

To find out more, please contact
healthinnovation-em@nottingham.ac.uk