Health Innovation Network

Local change, national impact

NHS England

National Patient Safety Improvement Programmes

2025-2026 Impact Report

Contents

Introduction

Six years ago, the NHS Patient Safety Strategy was published, with specific areas of focus and an ambition to save 1000 extra lives and £100m every year from 2023/24 (excluding litigation costs). In July 2024, the NHS 10-year Health Plan focused on three strategic shifts: moving care from hospitals to communities, transitioning from analogue to digital services and emphasising prevention over treatment. The Patient Safety Programmes outlined in this report support this direction of travel and the three strategic shifts.

Since 2014 the NHS England Patient Safety team has commissioned the Patient Safety Collaboratives (PSCs), hosted by the 15 health innovation networks, to support with the NHS' aim to continuously improve patient safety. Their main objective since the strategy's publication has been to support its implementation. PSCs also work collaboratively to reduce harm, promote a culture of safety, and support adoption of evidence-based practices within healthcare settings. They support national programmes in locally adapted ways across systems, some examples of which are included in this report.

This report summarises the progress across the National Patient Safety Improvement Programmes (NatSIP) in 2025/26, and the impact of the PSC's work in this area to date.

"I speak on behalf of all our colleagues across the health innovation networks when I say how privileged we feel to host the 15 Patient Safety Collaboratives across England. Through these we contribute to the delivery of the NHS Patient Safety Strategy by supporting frontline teams to translate national ambitions into practical activity on the ground.

By being firmly embedded as a trusted partner in each of our local health and care systems, we are able to serve as an effective 'ground force'. Our commitment to empowering staff is helping to drive the successful implementation of national safety priorities, standardising care by removing variation, improving safety and saving lives as a direct result."

Natasha Swinscoe, Chief Executive of Health Innovation West of England, and Chief Officer Lead for Patient Safety, Health Innovation Network.

The NHS Patient Safety Strategy

Continuously improving patient safety

Insight

Improve our understanding of safety by drawing insight from multiple sources of patient safety information.

Involvement

People have the skills and opportunities to improve patient safety, throughout the whole system.

Improvement

Improvement programmes enable effective and sustainable change in the most important areas.

A patient safety ***culture***
A patient safety ***system***

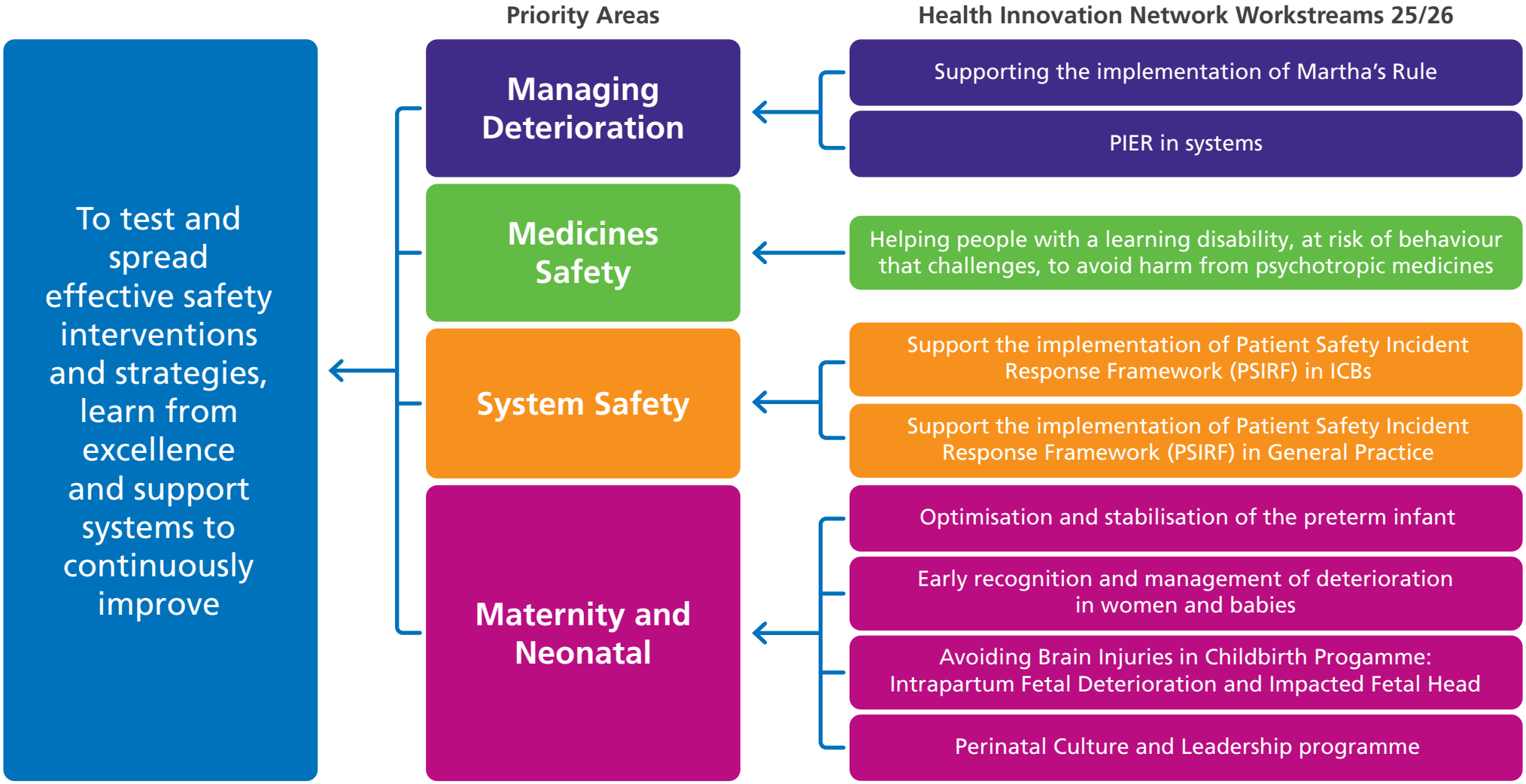
The NHS Patient Safety Strategy estimated that it would save

1,000 extra lives

£100 million
every year from 2023/24 excluding litigation costs

National Patient Safety Improvement Programmes (NatSIP)

Delivered by the 15 PSCs in support of the ambitions of the NHS Patient Safety Strategy



NHS Patient Safety Improvement Programmes: Impacts to date

5,137
lives saved

Medicines Safety

2,597
lives saved

Halved the risk of death for
31,485
pain sufferers

34
severe harms avoided due to management of antipsychotic medicines in people with a learning disability

Managing Deterioration

Prevented over
44,969
emergency admissions in care homes

574
potentially life-saving interventions triggered

Maternal and Neonatal Safety

Saved up to
1,966
lives

Prevented up to
608
cases of cerebral palsy

Impacts from 2018 to March 2026.

> **The Patient Safety Collaboratives have been instrumental in turning the ambitions of the NHS Patient Safety Strategy into practical improvement across the country. Through their improvement expertise, leadership and local partnerships, they have strengthened outcomes in maternity, deterioration management, medicines safety and wider system safety.**
>
> **Their ability to translate improvement science into frontline action has provided invaluable support to systems and clinical teams alike. The progress achieved through programmes such as Martha's Rule reflects their commitment to collaboration, continuous learning and relentless focus on safer care for patients.**

Heather Pritchard,
Head of Martha's Rule and Patient Safety Improvement Programmes,
NHS England

Health Innovation Network

Local change, national impact

Managing Deterioration: Martha's Rule

The Patient Safety Commission is delivered by the 15 health innovation networks

Managing Deterioration: Martha's Rule Programme

Martha Mills died in 2021 after developing sepsis in hospital, where she had been admitted with a pancreatic injury after falling off her bike. Martha's family's concerns about her deteriorating condition were not responded to, and in 2023 a coroner ruled that Martha would probably have survived had she been moved to intensive care earlier. In response to this and other cases related to the management of deterioration, the Secretary of State for Health and Social Care and NHS England committed to implement the Patient Safety Commissioner's recommendation of 'Martha's Rule'; to ensure the vitally important concerns of the patient and those who know the patient best are listened to and acted upon.

Key Deliverables

Programme aim: Support 210 acute hospital sites to test and implement Martha's Rule.

Network involvement: Work with sites and key stakeholders to identify and understand the impact of Martha's Rule by supporting the development of local measurement plans that can inform learning and show impact of Martha's Rule.

The 3 components of Martha's Rule are:

1. Patients will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structured way.
2. All staff will be able, at any time, to ask for a review from a different team if they are concerned that a patient is deteriorating, and they are not being responded to.
3. This escalation route will also always be available to patients themselves, their families and carers and advertised across the hospital.

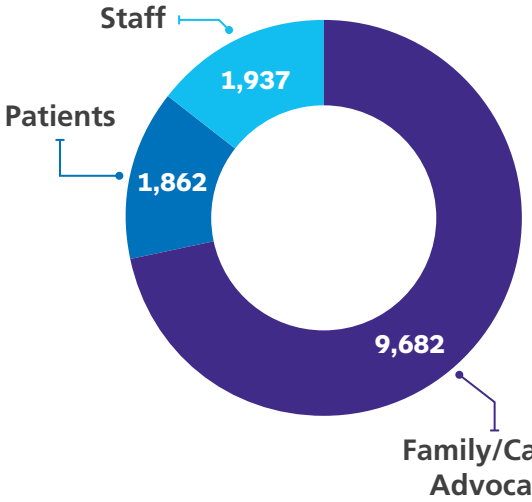
Impacts

Martha's Rule is improving outcomes for patients and increasing sensitivity to deterioration.

Martha's Rule Programme

From Sept 2024 – March 2026

13,481
escalations calls received



4,336
escalations calls related to acute deterioration

574
Potential lives saved
as a response to transfers of care to adult or paediatric ICU/ HDU, enhanced levels of care or tertiary centres

June 2025 - March 2026

81%
of acute deterioration would not have triggered escalation via the early warning score.

1,930
Other changes in treatment

- New medications and antibiotics
- Investigations / diagnostics
- Procedural interventions
- Optimisation of IV fluids, oxygen, secretion management, pain or changes to nursing care

Calls not categorised as being related to acute deterioration are still supporting staff to provide better care and address concerns. For example, **3,340** calls led to **clinical concerns such as medication or investigation delays being addressed.** A further **3,360** calls helped to resolve **communication and discharge planning issues**. Statistics » Martha's Rule Programme March 2026

Implementation in action: Martha's Rule Case Studies

Working with systems and partners across health and social care, patient safety teams support adoption and scale of safety initiatives in locally relevant and adapted ways. Here are just a few examples of how Martha's Rule has been applied in local systems.

Case study 1:

Health Innovation East

Elaine's Story

Elaine's daughter recognised something was not right and was able to escalate her concerns through Martha's Rule. Elaine received swift diagnosis and treatment.

Outcomes/impact:

- Rapid escalation saves lives: the swift response from Martha's Rule team enabled an urgent diagnosis and treatment of a stroke.
- Empowering families and staff: Martha's Rule provided a clear, accessible route for families and frontline staff to escalate concerns.
- Patient-centered outcomes: Elaine's full recovery highlights the value of early intervention and collaborative decision-making in acute care settings.

Read full case study on page 11.

Case study 2:

Health Innovation WEST MIDLANDS

Implementing Patient Wellness Questionnaires, one of the three elements of Martha's Rule

Method: The Dudley Hospital group implemented the PWQ into the hospital Electronic Patient Record (EPR) system vital signs, taking a patient-centered approach, reinforced with Trust-wide mandation to ensure adoption.

Outcome:

- Trust-wide adoption.

Impacts:

- Cultural change regarding listening and asking questions.
- 33% did not have raised NEWS scores, suggesting Martha's Rule is an early identification of deterioration.

Read full case study on page 12.

Case study 3:

Health Innovation WEST MIDLANDS

'Call for Concern' now called Martha's Rule: University Hospitals Birmingham

Method: Used a structured approach to implementation. Including setting up a clear governance process and stakeholder engagement plan.

Outcomes/impact:

- Successful implementation of all 3 components.
- A total of 246 calls have been raised since 'go live'.
- Just under half (43%) of calls were related to a clinical matter, however, only 6% of the calls qualified for a review by the Critical Care Outreach Team.

Read full case study on page 13.

Implementing Martha's Rule: Elaine's Story

Health Innovation East

Elaine is an active 81 year-old women, who enjoys walking and keeping busy. She had recently travelled to Italy to spend time with friends and family. On return from her trip, Elaine slipped on the pavement and broke her leg. The bone was surgically pinned, and her initial recovery seemed to be going well. Elaine kept in touch with her daughter, Diane, for the next few days – exchanging regular messages that reassured Diane that her mother was recovering well. After returning from her own trip to Italy, Diane planned to visit her mother in hospital with her husband.

Recognising something wasn't right

The first sign that alerted Diane that something wasn't quite right was when the regular messages between the pair stopped. Later that day Diane was able to visit her mother and noticed straight away that something was wrong with Elaine.

"Her mouth was squint, she was trying to eat yoghurt and it was running down her chin. Her glasses were also sitting wonky on her head and she was speaking in a really strange way. I turned to my husband and said 'she's had a stroke'."

Diane alerted a nurse, who also noticed that Elaine seemed different from earlier that day. A healthcare assistant also shared the same concern and so the issue was escalated to a senior nurse on duty. An initial assessment was carried out, however the assessment team did not believe there was a cause for concern at that stage. Still concerned, Diane asked to see a doctor, who carried out further tests and reassured Diane that Elaine appeared fine but said they would do further checks the following day if her condition didn't improve.

Escalation via Martha's Rule

Diane spotted a Martha's Rule poster displayed on the wall in the corridor and with the encouragement of a nurse called the number. Within minutes the hospital's Martha's Rule critical care outreach team answered the call and listened to Diane's concerns.

Two nurses arrived on the ward within nine minutes and interviewed Diane and her husband to understand Elaine's usual behaviour and personality, they also spoke to the staff members who had expressed concern. After reviewing the situation, they decided there was enough justification to carry out an urgent stroke assessment.

Swift diagnosis and treatment

Elaine was taken for a brain scan within an hour of the Martha's Rule call being made. That evening, a consultant phoned Diane to confirm the scan had revealed a clot on the brain which was successfully removed. Elaine was back to normal with no lasting damage from the stroke.

Elaine is now back home and continuing her recovery. Diane credits the speed of Martha's Rule progress for the recovery of her mum:

"The critical care outreach team answered the phone so quickly, they were professional and the speed at which the first two people arrived after I called was incredible – because of the fast action my mum able to receive treatment and was back to normal quickly."

Key takeaways:

- Rapid escalation saves lives: the swift response from Martha's Rule team enabled an urgent diagnosis and treatment of a stroke.
- Empowering families and staff: Martha's Rule provided a clear, accessible route for families and frontline staff to escalate concerns.
- Patient-centred outcomes: Elaine's full recovery highlights the value of early intervention and collaborative decision-making in acute care settings.

Implementing Martha's rule: Digital Patient Wellness Questionnaire (PWQ)

The Dudley Group NHS Foundation Trust

Digital Implementation of PWQ within an Electronic Patient Record (EPR): alignment to existing Deteriorating Patient Pathway

Dr Adrian Jennings Consultant Anaesthetist, Clinical Director for Patient Safety, Siân Annakin Deteriorating Patient Lead, The Dudley Group NHS Foundation Trust, Russells Hall Hospital

martha's rule detecting deterioration

DPPathway Deteriorating Patient Pathway

Health Innovation WEST MIDLANDS

Summary

- Implemented Patient Wellness Questions (PWQ) into EPR vital signs.
- Made mandatory so immediate Trust-wide adoption.
- Harmonisation with Deteriorating Patient Pathway (DPP).
- Challenge: ensuring the culture changes and this isn't a tick box exercise.

Context

- Long established DPP and e-Obs within Altera Sunrise EPR for adults, paeds and maternity. DPP follows the Prevent, Identify, Escalate, Respond (PIER) approach.
- Anticipated difficulty introducing a new ward process for PWQ if taken in isolation. Felt easiest to embed in existing vital signs rounds.

Methods

- NEWS2/NPEWS/MEOWS included.
- Twice daily mandating of PWQ: first e-Obs taken after shift changes at 7am and 7pm.
- Patient Wellness score and risk calculated by EPR.
- Soft signs also included if patient unable to do PWQ.
- Red Patient Wellness score activates our DPP equivalent to a medium clinical risk scenario.
- PowerBI informatics dashboard monitoring.

EPR Implementation

Patient Wellness (Contains Unsaved Data)

Martha's Rule - Ask at least once per shift

How are you feeling?

How are you feeling compared to the last time you were asked or yesterday?

Do you understand your current management plan?

Soft signs present (If patient unable to answer questions)

- Very good
- Good
- Fair
- Poor
- Very poor
- Unable to answer

- Much better
- Better
- No change
- Worse
- Much worse
- Unable to answer

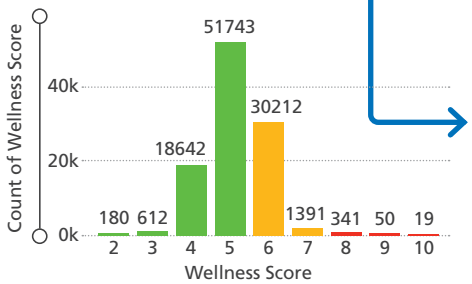
- New or increased confusion
- Agitation / anxiety / pain
- Changes to usual level of alertness / consciousness / sleeping more
- Increasing breathlessness or chestiness
- Change in usual drinking / diet habits
- New offensive / smelly urine or can't pee / reduced pee
- Increasing oxygen requirement
- A shivery fever - feels hot or cold to touch
- Reduced mobility - 'off legs' / less coordinated
- New rash or mottling
- Concerns from family / carers that the patient is not as well as usual

Patient Wellness Score Decision Matrix

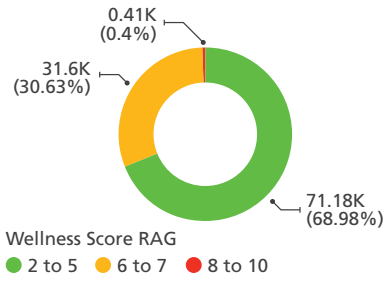
2	3	4	5	6
3	4	5	6	7
4	5	6	7	8
5	6	7	8	9
6	7	8	9	10

2-5	Continue to monitor
6-7	• Registered Nurse to recheck observation and undertake an ABCDE assessment. • Escalate score to Nurse in Charge for consideration of a medical review. • Consider increased observation frequency. • Consider fluid balance. • Consider further investigations.
8-10	Activate DPP (medium risk)

Patient Wellness Scores



Patient Wellness Scores



Conclusions

- PWQ being asked in all inpatient areas twice/day.
- 0.4% have red PWQ.
- Approximately one third of these do not have simultaneous raised Early Warning Score (EWS) or professional concern.
- Measuring if this has had a cultural impact on asking and listening is difficult to assess as an EPR necessarily provides quantitative and not qualitative data.

Implementing Martha's Rule: Taking a structured approach

University Hospitals Birmingham
NHS Foundation Trust

Health Innovation WEST MIDLANDS

Call for Concern

Components

Component one
Patients will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structured way.

- Tested in Acute Medical Unit (AMU) at Queen Elizabeth Hospital and Birmingham Heartlands Hospital.
- Patient Wellness Score being developed for electronic Prescribing Information and Communication System (PICS).
- To be launched Trust-wide June 2026.

Component two
All staff will be able, at any time, to ask for a review from a different team if they are concerned that a patient is deteriorating, and they are not being responded to.

- This is already an established pathway at University Hospitals Birmingham (UHB) and this was established prior to the launch of Call for Concern.

Component three
This escalation route will also always be available to patients themselves, their families and carers and advertised across the hospital.

- This was successfully implemented across UHB in March 2025 throughout all inpatient settings.

Implementation and learning

Learning:
- Looking from a patient pathway perspective.
- Stakeholder engagement facilitating outreach service in providing this (difficult conversations, additional training).

Challenges:
- Timeframe, meeting the needs of the local community.

> **I contacted the CCOT using the new Martha's Rule that is in place when me and my family were severely worried about our loved one in hospital. Within 1 hour of me calling them they went to review my brother and potentially saved his life by ensuring investigations and treatments were completed in a prompt manner.**
>
> **Despite being extremely busy they made time to explain everything to us and provide the reassurance and hope we needed. We cannot thank you enough, we will forever be grateful for your understanding and support.**

Results and impact

Total Concerns Raised
532

Average Patient Age
56

Clinical Matters Raised (%)
43%

Qualified for Review (%)
3%

- A total of 246 calls have been raised since 'go live'.
- Just under half (43%) of calls were related to a clinical matter, however, only 6% of the calls qualified for a review by the Critical Care Outreach Team.
- The majority of calls are made between 12:00 and 22:00.

Health Innovation Network

Local change, national impact

Medicines Safety:

Helping people with a learning disability, at risk of behaviour that challenges, to avoid harm from psychotropic medicines

The Patient Safety Commission is delivered by the 15 health innovation networks

Helping people with a learning disability, at risk of behaviour that challenges, to avoid harm from psychotropic medicines

NHSE MedSIP approach is to *"Enable and support local innovation rather than dictate it."* What Should National Policy-Makers Do To Make Care Closer To Home A Reality? | The King's Fund.

The 15 Patient Safety Collaboratives (PSCs) were commissioned to guide and support ICBs and organisations at a local level through a tried and tested approach to whole system improvement (WSA7).

This will support a Neighbourhood Health approach by considering how best to deliver the right wraparound support for individuals, placing social care, local authority, and voluntary, community, faith and social enterprise (VCFSE) sector organisations as partners alongside the NHS.

Key Principles for delivery

Proactive care planning and shared decision making

Non-pharmacological management

Multi-agency system working

Holistic support and improved accessibility

Balance short and long-term health needs

1. Management of behaviour that challenges requires **proactive care planning and shared decision making** with patients and their carers/advocates, that incorporates **psychosocial and environmental support*** to reduce overprescribing of psychotropics and the associated avoidable harm.

2. Multi-agency, system working is vital to ensure a co-ordinated approach that enables **holistic support and improved accessibility** across the entire pathway of care.

3. A recognised challenge is how to **balance short and long-term health needs and goals** in this patient group, weighing up the risk versus benefits of using psychotropics which is often complicated by a fear of destabilisation and variability in access to non-pharmacological management*.

Key Deliverables

Support ICSs to implement the seven phase Whole System Approach Framework across a minimum of two neighbourhoods.

** e.g. Positive Behavioural Support (PBS), sensory integration, social prescribing and psychological approaches including mindfulness and lifestyle interventions.*

Programme Outcomes

By bringing health, care and community partners together to understand local need and strengthen psychosocial and environmental support, the programme is reducing inappropriate long-term antipsychotic prescribing and helping people with a learning disability achieve better health, wellbeing and quality of life.

Outputs:

- Local understanding of the problem and improvement is codesigned with the whole system.
- Coordinated activity in primary, secondary and community care supporting Neighbourhood Health and a shift to prevention, improving timely review, de-escalation and management.
- Systems convene to share learning, with a view to developing iterative, data driven improvement.
- Movement towards a Learning Health System at local level to support continuous improvement and sustainability.

- 22 ICBs are creating the conditions for **whole system improvement** in a complex problem.
- 1,335 GP practices submitting data.
- 4 novel GP Clinical system searches launched for use across England to understand local prescribing of antipsychotics for people with a learning disability.

Outcomes:

- Decreased number of people on the GP Learning Disability register and not on the Severe Mental Illness (SMI) register prescribed antipsychotic medication (of any dose) for >3 months versus baseline.
- Increased availability, accessibility, awareness and uptake of specialist behavioural support in the community including psychosocial and environment support.

102 fewer people prescribed long-term antipsychotics equating to

34 severe harms avoided

Implementation in action: local adaptation of national principles

The medicines safety programme has been implemented locally, developed in partnership with local systems/organisations to respond to local population needs. Here are just two examples of how this has worked differently across England.

Case study 1:

Lived Experience Collaborative

Health Innovation Yorkshire & Humber

Health Innovation Yorkshire and Humber engaged people with learning disabilities to better understand their lived experiences and inform safer, more person-centred care.

Working in partnership with the Yorkshire Improvement Academy and Ivy Care, facilitators used a trusted group and creative, accessible methods—particularly collage-making—to explore key questions about emotional triggers, coping strategies, and attitudes to medicines.

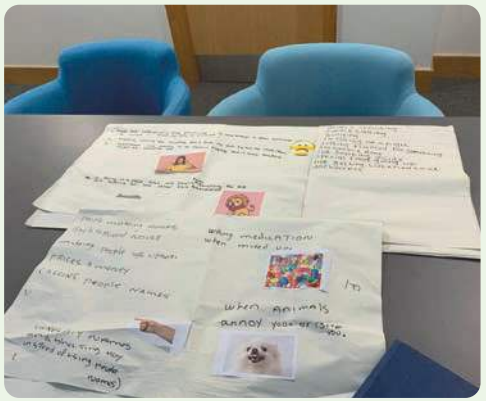
The session involved adults with mild learning disabilities and additional health needs, in a familiar environment supported by experienced Patient and Public Involvement and Engagement (PPIE) facilitators. This approach enabled open discussion and authentic insights into how individuals experience distress, interact with services, and think about medication.

Improvement Academy

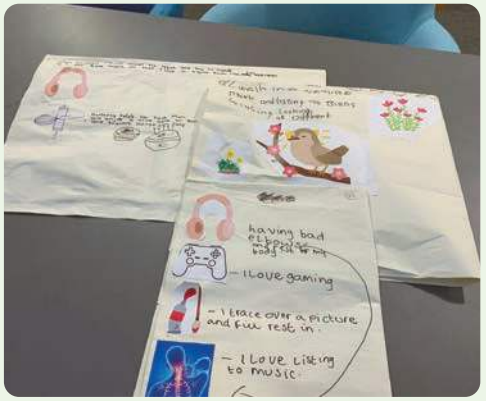
Ivy Care Inclusive Quality Care

Health Innovation Network Local change, national impact

Making the collages



Causes of anger, frustration and sadness



Activities which help indviduals feel better

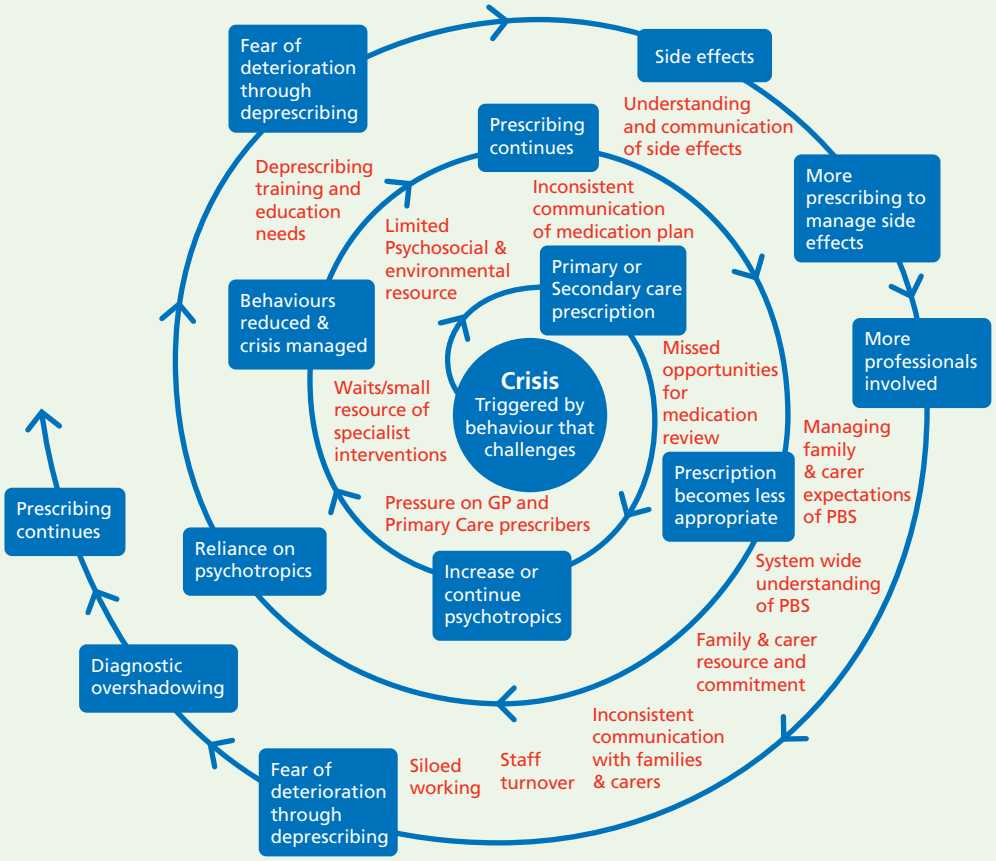
Implementation in action: local adaptation of national principles

Case study 2:

System Mapping

Health Innovation Oxford and Thames Valley have been supporting Thames Valley ICB in the delivery of the national Medicines Safety Improvement Programme: Helping people with a learning disability, at risk of behaviour that challenges, to avoid harm from psychotropic medicines. In November 2025, as part of system mapping activities, stakeholders across services and sectors in the Royal Borough of Windsor and Maidenhead (RBWM) came together to explore the challenges, factors and drivers that influence high-risk prescribing in this population. The Prescribing Spiral was formed to illustrate these insights through an example patient journey from point of crisis to long-term continued prescribing, and the challenges and barriers that impact patients, families and professionals.

A follow-up workshop brought stakeholders together to build on the discovery phase insights. Activities focused on developing opportunities into change ideas and drafting a shared vision statement. The pilot will focus on prevention, with potential improvements including increasing awareness of appropriate prescribing, quality standards, and best practice through cross-sector learning; delivering targeted teaching for trainee GPs; and improving the accuracy and timeliness of information sharing on psychosocial interventions. In 2026/27, an online vote will prioritise change ideas and agree the final vision statement, providing direction for subsequent improvement activity.



'Prescribing Spiral'
Created with input from attendees across healthcare, adult and children's social care and local VCSEs in RBWM - stakeholder event November 2025

Health Innovation Network

Local change, national impact

Maternity and Neonatal Safety

- Optimisation and stabilisation of the pre-term infant
- Early recognition and management of deterioration of women and babies
- Perinatal culture and leadership programme
- Avoiding Brain Injury in Childbirth (ABC)

The Patient Safety Commission is delivered by the 15 health innovation networks

Optimisation and stabilisation of the pre-term infant

The NHS maternity and neonatal pre-optimisation care bundle is a set of evidence-based interventions designed to improve outcomes for babies born prematurely (before 34 weeks gestation) or with other complications and is aligned to NHS England best practice for reducing baby mortality (Saving Babies Lives V3). It focuses on optimising care before and during birth. The goal is to reduce variations in care and improve outcomes for mothers and babies across England.

Key Components of the Care Bundle:

- **Place of Birth:** Ensuring appropriate level of care based on the risk assessment and gestational age.
- **Antenatal Steroids:** Administering corticosteroids to the mother before birth to help the baby's lungs develop.
- **Magnesium Sulphate:** Administering magnesium sulphate to the mother before birth to help protect the baby's brain.
- **Intrapartum Antibiotics:** Providing antibiotics to mothers at risk of infection.
- **Optimal Cord Management:** Delaying clamping of the umbilical cord to allow for blood flow to the baby.
- **Normothermia:** Maintaining a stable body temperature for the baby after birth.
- **Maternal Breast Milk:** Encouraging and supporting breastfeeding, as it provides essential nutrients and antibodies for the baby.
- **Volume targeted ventilation:** to minimise lung injury.
- **Caffeine:** stimulates the babies respiratory centre and helps regulate breathing.

Programme Ambitions

- Increase in rates of babies surviving until discharged home.
- Reduction in brain injury.
- Reduction in incidents of necrotising enterocolitis.
- Reduction in bronchopulmonary dysplasia.

Key Deliverables

Enhance the effectiveness of the preterm optimisation bundle across 100% of maternity and neonatal units in England.

Impacts

Delivering on our ambitions, improving outcomes and saving lives for babies and families across England

1,000
more interventions per month since 2020 = 2725 per month

858
babies avoided Strep B*

214
lives saved

608
cases of cerebral palsy avoided, and

£608 million
costs avoided in long-term social care and health needs.

Data cumulative since 2018

341
babies survived due to antenatal steroids*

1,411
babies survived due to optimal cord management*

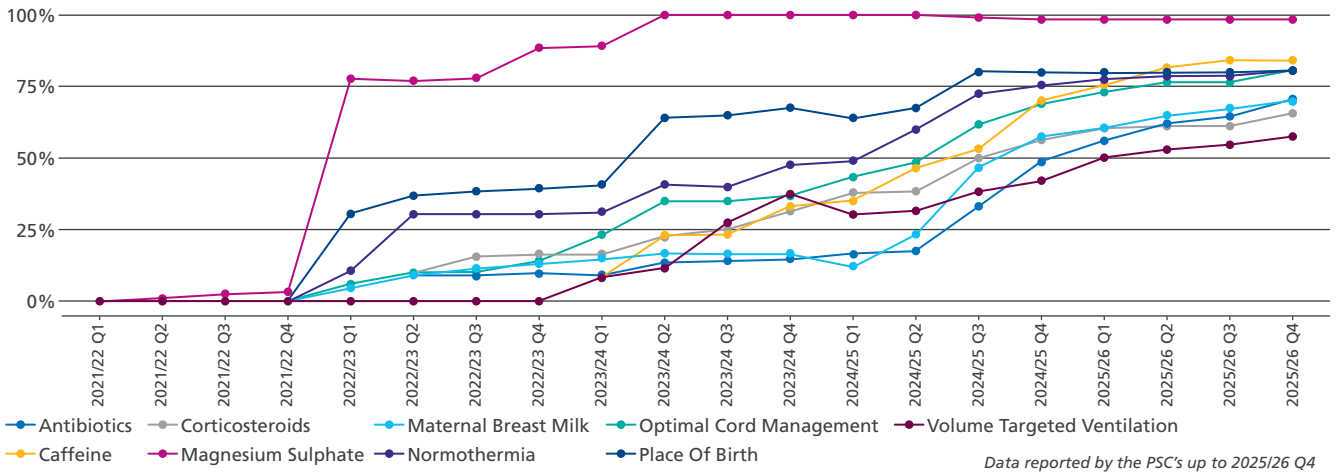
1,966
babies survived because of receiving the care bundles*

**Data cumulative since 2020*

Sustaining impact: continued improvement through the adoption of the optimisation care bundle across England

Adoption of optimisation interventions across NHS Trusts

Percentage of organisations reporting all implementation stages at level 7, by intervention



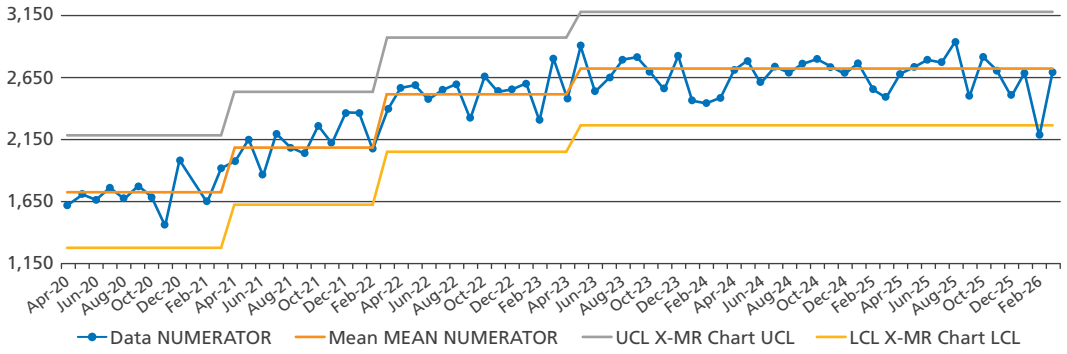
Data reported by the PSC's up to 2025/26 Q4

We continue to see increases in the individual interventions being sustained for 12 months or more.

The rising number of interventions being given each month has resulted in a national increase of 1,000 interventions each month. This remains reliably consistent.

Nationally, 2,725 interventions have been given to babies born preterm.

National Position Total interventions X-MR Chart



Case Studies

Working with systems and partners across health and social care, patient safety teams support adoption and scale of safety initiatives in locally relevant and adapted ways. The following case studies are examples of how the maternity and neonatal safety Optimisation and Stabilisation of the Pre-Term Infant programme has been implemented locally.

Case study 1:

Improving Maternal Breast Milk (MBM)

Approach: Patient information leaflets, targetted midwife and maternity support worker education, integrated mandatory training scenarios and staff recognition scheme were used directly to enhance the proportion of infants receiving MBM within the first 24 hours of life.

Results:

- Wythenshawe hospital reduced time between delivery and expression.
- Increase in number of babies receiving MBM.

Read full case study on page 24.

Case study 2:

Multi-Profession Simulation-Based Training

Approach: A Multi-Professional Simulation Based Education was created to build skills among front line clinicians to implement the objectives of the British Association of Perinatal Medicine (BAPM) Framework on Extreme Preterm Birth1 and the Mat/Neo Safety Improvement programme.

Results:

- Promoted collaboration between maternity and neonatal teams to enhance both clinical and non-technical skills which informed the successful management of pre-term birth.

Read full case study on page 25.

Case study 3:

Manage Together

Approach: Integrated maternity-system training delivered jointly across the community midwifery team and the ambulance service.

Results:

- Improved processes for the efficient management of maternity and neonatal emergencies and safe transfer into hospital.

Read full case study on page 26.

Implementation in action:

NHS
Manchester University
NHS Foundation Trust

Improving Maternal Breast Milk provision at MFT Wythenshawe

Background

Maternal breast milk (MBM) is the optimal source of nutrition for preterm infants, offering significant benefits for neurological, gastrointestinal, immunological, and long-term health outcomes. In addition to neonatal health, successful provision of breast milk and breastfeeding also positively impact maternal mental well-being. Our objective was to enhance the proportion of infants receiving MBM within the first 24 hours of life and to improve the timeliness of hand expression support, thereby promoting sustained breastfeeding success.

Solution

In quarter 3 of 2024–2025, a preterm birth trolley was introduced, equipped with patient information leaflets covering all aspects of neonatal optimisation. These included the benefits of maternal breast milk for preterm infants and guidance on hand expression techniques.

In quarter 4 of 2024–2025, targeted education was delivered to midwives and maternity support workers, highlighting the importance of breast milk for preterm babies and the impact of initiating hand expression within two hours of birth on milk supply at 1, 3, and 6 weeks postnatal. This information was disseminated through ward hotspots, integrated into mandatory training scenarios, and shared via the Trust's closed Instagram page.

To celebrate and reinforce excellent practice, staff "Shout Outs" were sent to team members who supported timely hand expression.

The infant feeding team now proactively visits women admitted to the antenatal ward with threatened preterm labour, they provide resources on hand expression and the benefits of breast milk should their baby be born early. They also support postnatal women whose babies are on the neonatal unit with hand expressing.

A Preterm Champion Midwife has been appointed on the Delivery Suite to advise and support colleagues when delivering care to women admitted in preterm labour.

Health Innovation Manchester

Challenges

- Managing task volume in the immediate postnatal period continues to be a challenge for maternity staff, particularly when births occur due to maternal complications.
- Times of increased clinical activity can limit the availability of additional team members to assist with maternal care or provide timely support for hand expression.

Learning

- Patients valued resources they could keep and refer to or share with their support people.
- The preterm birth trolley has been very positively received and is used by the team to commence optimisation promptly and in a standardised way.
- The infant feeding team's support has helped women with the practical aspect of hand expressing and reinforces the importance of MBM.

Conclusion

We have seen consistent improvement with MBM by 24 hours since the launch of the preterm trolley and a significant improvement in timeliness of hand expression since the staff education and infant feeding team input has been formalised.

	Q3 24-25	Q4 24-25	Q1 25-26
MBM by 24 hours	50%	73%	75%
Average time between delivery and hand expression	7.9 hours	10.9 hours	2.4 hours

Implementation in action:

Enhancing skills and confidence in managing preterm birth

Oxford University Hospitals
NHS Foundation Trust

Multi-professional Simulation Based Education: A critical tool for managing pre-term birth.

Eileen Dudley[1], Anda Bowring[2], Samantha Fleming[3], Michelle East[4]

Health Innovation
Oxford & Thames Valley

Introduction

Aims:

- To build skills among front line clinicians to facilitate effective in-situ simulation that will:
  - Promote psychological safety in the learning environment and within front line teams.
  - Enhance perinatal team confidence and decision-making skills in relation to managing preterm birth.
  - Implement the objectives of the BAPM Framework on Extreme Preterm Birth[1] and the Mat/Neo Safety Improvement programme[2].
  - Foster multi-professional collaboration (BAPM Building Successful Perinatal Optimisation Teams[3]).

Background

Preterm Birth:

- Responsible for 69% of deaths in the first year of life with disproportionately poorer outcomes for minority ethnic backgrounds[4].
- Intelligence from a series of co-produced surveys and focus groups highlighted the need for bespoke education and training.
- Optimisation measures are fundamental to reducing mortality and morbidity[5].
- There has been an increase of 15.2% of all elements of perinatal optimisation met, from 2021/22 to 2023/24 (YTD) in our region. There is further scope for improvement and sustainability.

Yet there are no recognised education programmes to improve quality or safety of care.

Discussion

- We designed a Simulation Based Education programme working with education teams, academic partner and healthcare professionals in each of our trusts.
- The model delivers maximum impact with minimum time away from clinical care.
- Can be delivered as In Situ Sim or part of a Study Day.
- Underpinned with clinical scenarios- simplicity is key so low fidelity simulation.
- A focus on the pre-brief and the debrief.
- Pilot workshop (Dec 2023) positively evaluated. Spread to organisations in Thames Valley region.
- Formal evaluation by Bucks New University and opportunities for spread to be identified.

Implications for Practice

- Pre and post course evaluation has shown that the participants feel that their skill and confidence in simulation has increased.
- Learning about psychological safety, prebrief and debrief practice will enhance education and training delivery locally.
- Promotes collaboration between maternity and neonatal teams to enhance both clinical and non- technical skills which inform the successful management of preterm birth.
- The training day is proving to be a valuable catalyst for generating innovative ideas that can be integrated into team training sessions.
- On going support via virtual Action Learning Sets.

Authors affiliation: 1. Health Innovation Oxford and Thames Valley, Patient Safety Collaborative MatNeo SIP Lead, 2. Oxford University Hospital NHS FT, Newborn Care Unit, ANNP, 3. Royal Berkshire NHS FT, Consultant Midwife, 4. Buckinghamshire Healthcare NHS FT, Director of Midwifery.

References: 1. BAPM Perinatal Management of Extreme Preterm Birth before 27 weeks of gestation A Framework for Practice, 2019; 2. NHS England, 2019. Maternity and Neonatal Safety Improvement Programme, NHS England https://www.england.nhs.uk/mat-transformation/maternal-and-neonatal-safety-collaborative 3. BAPM "Building Successful Perinatal Teams" A Toolkit to support delivery of the Perinatal Optimisation Pathway, 2023. 4. NCMD National Child Mortality Database Knowledge, understanding and learning to improve young lives, 2022. Child Death Review Data. [Online] Available at: https://www.ncmd.info/publications/child-death-review-data-release-2022 5. MBRRACE data https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2023/MBRRACE-UK_Maternal_Compiled_Report_2023.pdf

Implementation in action:

Integrating maternity-system training

NHS
Royal United Hospitals Bath
NHS Trust

NHS
South Western Ambulance Service
NHS Foundation Trust

Health Innovation West of England

Background:

Across all recent maternity inquiries, failures in teamwork, escalation, and cross-boundary working have been found to directly contribute to harm and enhanced realistic multidisciplinary training has been advocated.

We wanted to ensure that our maternity community emergency skills drills were collaborative with the ambulance service and tested the system.

Aims and objectives of the project:

- To facilitate integrated maternity-system training delivered jointly across the community midwifery team and the ambulance service.
- Increase confidence and competence for all healthcare professionals in managing obstetric emergencies in out-of-hospital settings, in line with PROMPT principles.

Proposed benefits of the quality improvement project:

- **Realistic context for decision-making:** Delivering training in real home environments ensures that the true conditions of a homebirth are considered, including limited space, lighting, equipment, and potential delays in accessing help.
- **Stronger multidisciplinary teamwork:** Training together helps build understanding of each other's roles, capabilities and limitations, and supports the development of a shared mental model for managing emergencies. This is especially important given the range of roles within the Ambulance Service, each with its own scope of practice and competencies.
- **Appropriate leadership:** Focused education on who is best placed to lead in different scenarios aims to support more efficient and effective management of real-life emergencies.
- **Testing system processes:** Realistic scenarios allow teams to identify areas for improvement in both equipment and wider system processes.
- **Reduced delays in escalation:** Joint training can help minimise delays that arise from uncertainty, hierarchy, or lack of clarity.
- **Improved communication under pressure:** Scenarios provide structured practice in clear, concise communication, including SBAR and closed-loop techniques.
- **Better understanding of escalation pathways:** Training clarifies when to call an ambulance, what information crews require, the support they can provide on scene, and how to coordinate an efficient transfer into hospital.
- **Enhanced confidence and competence:** Repeated exposure to emergency scenarios in community settings helps develop muscle memory for rare but critical events.
- **Alignment with national safety priorities:** The project directly supports recommendations related to teamwork, escalation, and cross-boundary learning.

Manage Together

Royal United Hospitals (RUH) Bath NHS Foundation Trust - Maternity System Training across Community Midwifery Teams and South Western Ambulance Service NHS Foundation Trust (SWASFT) Quality Improvement Project

> **Incredibly helpful to have this run in a home setting, emphasised the practicalities that need to be considered that cannot be reproduced in a usual training room environment. Working alongside midwife colleagues was so helpful for shared learning and understanding. Almost certainly the most beneficial training experience I have had as a paramedic.**
>
> Staff Feedback

Main successes of project:

- Improved processes for the efficient management of maternity and neonatal emergencies and safe transfer into hospital.
- Strengthened working relationships and improved collaboration between midwives and ambulance crews.
- 100% of attendees reported they would recommend the training day to others.
- 100% of attendees felt confident or extremely confident in managing emergency situations at home following the training.
- 87% of attendees rated each simulation as the most effective learning experience; the remaining participants rated the day as effective for learning.

Early recognition and management of deterioration of women and babies

Early recognition and management of deterioration in women and babies is crucial for improving outcomes. This involves using tools like Maternity Early Warning Scores (MEWS) and Newborn Early Warning Track and Trigger (NEWTT2) to identify subtle changes in vital signs and overall condition, prompting timely escalation of care. The PIER framework provides a structured approach to managing deterioration in both maternal and neonatal settings.

P	Plan/Prepare/Prevent	Care pathways, risk assessments, safety huddles
I	Identify	Early warning score tools
E	Escalate	Critical communication tools
R	Respond	Timely interventions, Enhanced maternity care

Programme ambitions

Improved communication between staff using a common safety critical language embedded within the PIER pathway.

Key deliverables

- Ensure the use of the national Maternity Early Warning Score (MEWS) tool is implemented in 100% of maternity units in England.
- Ensure the use of the Newborn Early Warning Trigger and Track (NEWTT2) tool is implemented in 100% of neonatal units in England.

Impact

Delivering safer care through the earlier recognition, escalation and management of deterioration in women and babies

68

Trusts are using MEWS

94

Trusts are using NEWTT2

Improved communication between staff using a common safety critical language embedded within the PIER pathway

Improved woman and family experience through engagement with healthcare professionals regarding escalating concern

Illustrative impact from one Maternity setting demonstrates:

Financial benefit:

avoiding Maternal Critical Care Unit (MCCU) admission saves approx.

£728–£1,050

per case, contributing to cost recovery of the

£21k

digital system

Significant reduction in sepsis-related admissions to Maternal Critical Care Unit (MCCU):

from

~15.8% to ~3.3%

(~79% relative reduction)

Implementation in action

Working with systems and partners across health and social care, patient safety teams support adoption and scale of safety initiatives in locally relevant and adapted ways.

The following case studies are examples of how the Early Recognition and Management of Deterioration of Women and Babies programme has been implemented locally.

Case study 1:

Health Innovation Manchester

Implementing MEWS in Maternity

Approach: A trust wide quality improvement project across Bolton NHS FT.

Results:

- Improved uptake of sepsis screening, though ongoing variability identified through audit.
- Increased consistency in assessment and escalation across maternity services.
- Reduction in overall MCCU admissions, improving patient outcomes and experience.

Read full case study on page 30.

Case study 2:

uclpartners
inventing healthcare's future

Positive Changes following the implementation of MEWS

Approach: Follow up of changes in Whittington Hospital 1 year after implementation.

Results:

- **Earlier recognition** of maternal deterioration.
- **More timely escalation,** reducing delays in senior review.
- **More objective and reliable handovers.**
- **Greater staff confidence** in identifying risk.
- **Improved documentation** reflecting structured clinical reasoning.
- **Cultural shift** toward evidence-based maternal surveillance.

Read full case study on page 31.

Implementation in action:

Implementing National MEWS in Maternity – Bolton NHS FT

NHS Bolton NHS Foundation Trust

Health Innovation Manchester

Background

Maternity Early Warning Score (MEWS) supports early identification of physiological deterioration and timely escalation in pregnant and postnatal women.

Variation in Maternity Obstetric Early Warning Score (MOEWS) approaches across the UK led to substantial variation in practice.

This project aimed to implement the national MEWS within maternity (Feb 2025) and scale across Bolton NHS Foundation Trust by April–May 2026, improving early recognition and escalation of deterioration.

Outcomes & Impact

- **Earlier recognition and escalation** of deteriorating women, with improved clinical response.
- Significant reduction in **sepsis-related admissions** to Maternal Critical Care Unit (MCCU): from **~15.8% to ~3.3%** (~79% relative reduction).
- Reduction in overall MCCU **admissions**, improving patient outcomes and experience.
- **Financial benefit:** avoiding MCCU admission saves approx. **£728–£1,050** per case, contributing to cost recovery of the **£21k** digital system.
- Improved uptake of **sepsis screening**, though ongoing variability identified through audit.
- **Increased consistency** in assessment and escalation across maternity services.

Intervention

- Trust-wide **Quality Improvement** project to standardise MEWS.
- Introduction of updated **policy, training, and ESR e-learning.**
- **Multi-disciplinary engagement** including midwifery, medical, anaesthetic and digital teams.
- Transition from paper-based MEWS to **digital integration** (Patientrack).
- **Audit programme** established to monitor compliance and outcomes.
- Targeted **communications and workforce mapping** to ensure appropriate staff training.

Challenges

- **Staff resistance and increased workload** ➜ Addressed through training, audit feedback and clinical leadership.
- **Unclear training requirements** ➜ Resolved via ESR/workforce mapping and mandated learning.
- **Digital delays and cost constraints** ➜ Phased approach (paper to digital, Patientrack implementation).
- **Data inconsistency and recording challenges** ➜ Standardisation through MEWS and move to digital systems.

Key learning

- Early multidisciplinary engagement is critical for system-wide adoption.
- Training, communication and audit feedback drive behaviour change.
- Digital systems are essential for consistency and data quality.
- Iterative audit cycles sustain improvement and identify variation.
- Clinical leadership enables cultural change and adoption.

Implementation in action:

Positive changes following the launch of National MEWS

Whittington Health NHS Trust

Background

The National Maternal Early Warning Score (MEWS) was rolled out at Whittington Hospital in April 2025 to strengthen early detection and escalation of maternal deterioration across maternity services. One year on, clear improvements have been observed in communication, clinical decision-making, and patient safety.

uclpartners inventing healthcare's future

Key improvements since implementation

1. More structured and consistent escalation

A notable change has been the routine use of MEWS scores during escalation conversations, with midwives consistently incorporating them into SBAR handovers when contacting obstetric or senior clinical teams.

- Staff now say "her MEWS is 5" rather than relying on subjective descriptions.
- This shift demonstrates increased confidence, standardisation, and effective use of an objective scoring tool.

2. Improved clinical situational awareness

Use of the aggregated MEWS score has encouraged staff to interpret vital signs holistically rather than in isolation.

- Teams are more aware of how individual physiological changes contribute to overall maternal risk.
- This supports clearer decision-making and earlier recognition of deterioration.

3. Enhanced management in acute clinical situations

A recent case involving a postnatal sepsis patient illustrates the impact:

- Although the patient appeared clinically unwell, the MEWS score of 5 acted as a critical escalation trigger.
- Documentation showed staff explicitly recognised and communicated the MEWS score, supporting timely review and management.
- This demonstrates that even when clinical symptoms are complex, MEWS provides a reliable early warning framework.

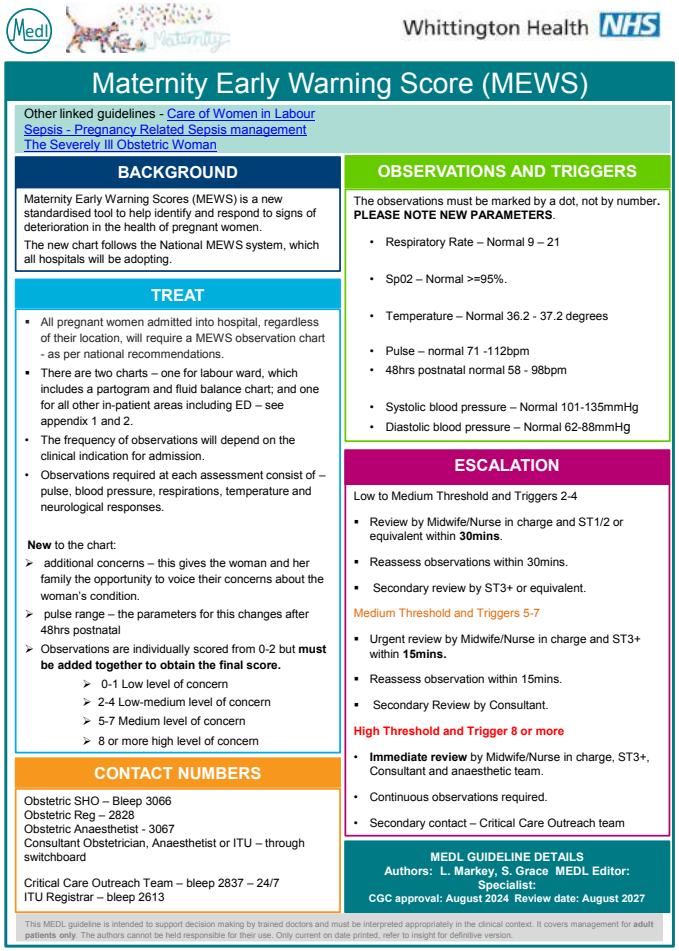
4. Strengthened interdisciplinary communication

The shared language provided by MEWS has improved coordination between midwives, obstetricians, anaesthetists, and senior decision-makers.

- Escalations are now clearer, faster, and more aligned with national guidance.
- This contributes to a safer, more consistent approach to maternal monitoring across the pathway.

Overall impact after one year

- Earlier recognition of maternal deterioration.
- More timely escalation, reducing delays in senior review.
- More objective and reliable handovers.
- Greater staff confidence in identifying risk.
- Improved documentation reflecting structured clinical reasoning.
- Cultural shift toward evidence-based maternal surveillance.



Whittington Health NHS

Maternity Early Warning Score (MEWS)

Other linked guidelines - Care of Women in Labour
Sepsis - Pregnancy Related Sepsis management
The Severely Ill Obstetric Woman

BACKGROUND

Maternity Early Warning Scores (MEWS) is a new standardised tool to help identify and respond to signs of deterioration in the health of pregnant women.
The new chart follows the National MEWS system, which all hospitals will be adopting.

TREAT

- All pregnant women admitted into hospital, regardless of their location, will require a MEWS observation chart - as per national recommendations.
- There are two charts – one for labour ward, which includes a partogram and fluid balance chart; and one for all other in-patient areas including ED – see appendix 1 and 2.
- The frequency of observations will depend on the clinical indication for admission.
- Observations required at each assessment consist of – pulse, blood pressure, respirations, temperature and neurological responses.

New to the chart:

- additional concerns – this gives the woman and her family the opportunity to voice their concerns about the woman's condition.
- pulse range – the parameters for this changes after 48hrs postnatal
- Observations are individually scored from 0-2 but **must be added together to obtain the final score.**
  - 0-1 Low level of concern
  - 2-4 Low-medium level of concern
  - 5-7 Medium level of concern
  - 8 or more high level of concern

CONTACT NUMBERS

Obstetric SHO – Bleep 3066
Obstetric Reg – 2828
Obstetric Anaesthetist - 3067
Consultant Obstetrician, Anaesthetist or ITU – through switchboard

Critical Care Outreach Team – bleep 2837 – 24/7
ITU Registrar – bleep 2613

OBSERVATIONS AND TRIGGERS

The observations must be marked by a dot, not by number. **PLEASE NOTE NEW PARAMETERS**.

- Respiratory Rate – Normal 9 – 21
- Sp02 – Normal >=95%.
- Temperature – Normal 36.2 - 37.2 degrees
- Pulse – normal 71 -112bpm
- 48hrs postnatal normal 58 - 98bpm
- Systolic blood pressure – Normal 101-135mmHg
- Diastolic blood pressure – Normal 62-88mmHg

ESCALATION

Low to Medium Threshold and Triggers 2-4

- Review by Midwife/Nurse in charge and ST1/2 or equivalent within **30mins**.
- Reassess observations within 30mins.
- Secondary review by ST3+ or equivalent.

Medium Threshold and Triggers 5-7

- Urgent review by Midwife/Nurse in charge and ST3+ within **15mins.**
- Reassess observation within 15mins.
- Secondary Review by Consultant.

High Threshold and Trigger 8 or more

- **Immediate review** by Midwife/Nurse in charge, ST3+, Consultant and anaesthetic team.
- Continuous observations required.
- Secondary contact – Critical Care Outreach team

MEDL GUIDELINE DETAILS
Authors: L. Markey, S. Grace MEDL Editor: Specialist:
CGC approval: August 2024 Review date: August 2027

This MEDL guideline is intended to support decision making by trained doctors and must be interpreted appropriately in the clinical context. It covers management for **adult patients only**. The authors cannot be held responsible for their use. Only current on date printed, refer to insight for definitive version.

Perinatal Culture and Leadership programme

The Perinatal Culture and Leadership Programme (PCLP) is an initiative by NHS England aimed at improving the safety and quality of maternity and neonatal care by fostering positive leadership and culture. It focuses on equipping senior leaders to create psychologically safe, inclusive, and compassionate working environments. The programme involves a "quadrumvirate" of senior leaders (Director of Midwifery, Operations Director, Clinical Director, and Neonatal Nurse Director) who work together to implement changes within their teams.

Teams used MOMENTS, a framework to support cultural development and drive improvements with front line teams (see next page).

Programme ambitions

To improve the quality of care for women, babies and families through compassionate and inclusive leadership.

Support perinatal leadership teams to create and craft the conditions for a positive culture of safety and continuous improvement.

To embed culture work in everyday practice.

Key deliverables

- Grow and sustain a perinatal approach to the PCLP.
- Grow and sustain the role of the Culture Coach.
- Facilitate and spread MOMENTS across 100% of maternity and neonatal units in England.

Case Studies

Working with systems and partners across health and social care, patient safety teams support adoption and scale of safety initiatives in locally relevant and adapted ways.

The following case studies are examples of how the maternity and neonatal Perinatal and Culture Leadership programme has been implemented locally.

Case study 1:

Supporting the development of a National Culture Coach Community of Practice across four health innovation networks

Approach: webinars were designed to support the development of the Culture Coach role and increase the awareness of ongoing work with teams.

Results:

- Greater confidence among staff to raise concerns, richer multidisciplinary collaboration, and improved understanding between midwifery, obstetric, neonatal and support staff groups.

Read full case study on page 34.

Health Innovation Wessex

Health Innovation Oxford & Thames Valley

Health Innovation East

Health Innovation Kent Surrey Sussex

Case study 2:

Strengthening cultural escalation practices

Approach: Interactive session to gain an understanding of cultural dynamics, enhance leadership behaviours, and co-create practical strategies to normalise safe, confident escalation in maternity settings.

Read full case study on page 35.

uclpartners
inventing healthcare's future

Results: Several themes emerged requiring further work

- Hierarchical barriers affecting escalation.
- Emotional fatigue and burnout within teams.
- Difficult conversations avoided due to fear of blame.
- A need for more visible, compassionate leadership.
- The challenge of staying values-led when systems feel pressured.
- The importance of recognising staff and celebrating strengths.

Examples of interventions to support PCLP

Health Innovation Oxford & Thames Valley

Approach:
Four examples of interventions:

1. **Use of MOMENTS**
2. **Active bystander training**
3. **Factors affecting colleagues taking breaks**
4. **Maternity wellbeing traffic lights**

Implementation in action: Supporting the development of the National Culture Coach Community of Practice

Health Innovation Wessex

To support the development of the national community of practice, the health innovation networks hosted a series of webinars aligned with the NHSE regional footprints.

The webinars were designed to support the development of the Culture Coach role and increase the awareness of ongoing work with teams.

Topics included: Culturally focussed QI in Perinatal environments, Creating the conditions for staff and patients to thrive, Active bystander and Allyship.

Health innovation networks have delivered improvement interventions in maternity and neonatal culture through the national Perinatal Culture and Leadership Programme, which are closely aligned with the national concerns raised in Baroness Amos's Interim Report into maternity and neonatal services (published 26 February 2026).

The report highlights persistent issues such as families feeling unheard, inconsistent care, fragmented pathways, and cultures where staff fear speaking up. Our approach offers a practical, system-level response. The programme uses the MOMENTS approach to help teams reflect on "how" care is delivered, uncover cultural barriers, and build stronger multidisciplinary relationships.

Early reflections show greater confidence among staff to raise concerns, richer multidisciplinary collaboration, and improved understanding between midwifery, obstetric, neonatal and support staff groups. Face-to-face sessions have been especially impactful, enabling honest dialogue and modelling positive behaviours.

Deliverable: Support the development and success of the national Culture Coach Community of Practice led by NHS England (milestone 4)

Objective 1: Build shared understanding of active bystander behaviours and their role in safety culture	**Objective 2:** Explore barriers and enablers to speaking up	**Objective 3:** Enable reflection, discussion, and practical application

SE Regional webinar:

- 77 attendees from:
  - 21 NHS organisations, 3 universities and 6 PSCs
- Range of perinatal roles including: PMAs/PNAs, Practice Educators and Practice Development Staff, Matrons, EDI Leads, Specialist Roles, Service Leads And Occupational Therapists

Architecting Safety: Moving from Individual Bravery to Systemic Accountability

Active Bystander

Active Bystander training: Driving Positive Behaviour change-

"That was very impactful - thank you"

"Thankyou so much -really insightful. Much appreciated"

"My pen couldn't move fast enough to capture all the wisdom. Thank you so much Angela"

Implementation in action:

Strengthening Cultural Escalation Practices Across NCL & NEL Maternity Services

Background

In response to challenges around communication, culture, and escalation within maternity services, two Cultural Escalation Sessions were delivered in partnership with Mokita Learning. These sessions brought together staff from four maternity and neonatal units across North Central London (NCL) and North East London (NEL), offering a supportive and reflective space to address how workplace culture directly influences escalation behaviours and patient safety.

The initiative aimed to deepen understanding of cultural dynamics, enhance leadership behaviours, and co-create practical strategies to normalise safe, confident escalation in maternity settings.

Objectives of the sessions

1. Understanding team culture and its Impact
2. Leadership reflection and self-awareness
3. Tools for tackling cultural challenges
4. Designing actionable plans

Themes discussed by participants

Across both sessions, several consistent issues emerged:

- Hierarchical barriers affecting escalation.
- Emotional fatigue and burnout within teams.
- Difficult conversations avoided due to fear of blame.
- A need for more visible, compassionate leadership.
- The challenge of staying values-led when systems feel pressured.
- The importance of recognising staff and celebrating strengths.

Staff also acknowledged how "being busy makes us forget to tell people how great they are", illustrating the need for simple but intentional daily leadership habits.

Participant feedback

Feedback reflected how valuable the safe, reflective environment had been:

"I really needed this right now."

"Given the time to pause and reflect and be able to talk to someone away from the organisation. It's a safe place to talk and share ideas."

"Coming here has given me the energy to keep going."

Participants repeatedly emphasised the benefit of stepping outside their operational pressures to reconnect with their leadership purpose.

Outcomes and next steps

The Cultural Escalation Sessions succeeded in:

- Strengthening leadership confidence.
- Building a shared language around culture.
- Creating momentum for behaviour-led change.
- Enabling teams to co-design practical escalation strategies.
- Reinforcing a psychologically safe environment across maternity units.
- Ongoing support and resources—including co-developed videos—are available to help teams continue embedding these practices.

Access the co-developed videos: Culture and leadership training

Implementation in action:

Examples of interventions to support PCLP

MOMENTS

THEMES

This infographic highlights key themes from four MOMENTS discussions held at the Matrons Forum at Hinchingbrooke Hospital on the 15th of January.

MEETING PURPOSE

Staff at the forum highlighted that meetings often lack a clear purpose, resulting in inappropriate attendance and discussions drifting away from the intended topics.

ESCALATION

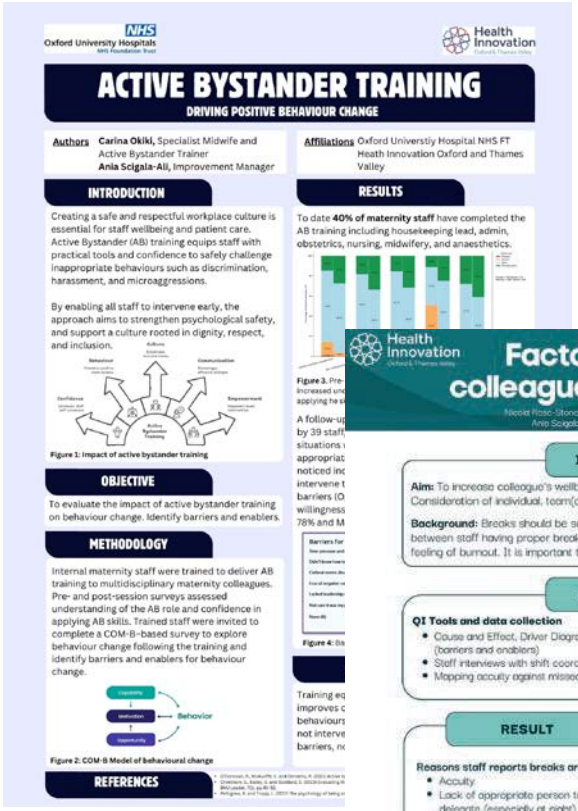
Staff frequently raise concerns via email to senior colleagues, limiting opportunities to address issues in real time and raising questions about approachability, availability and trust.

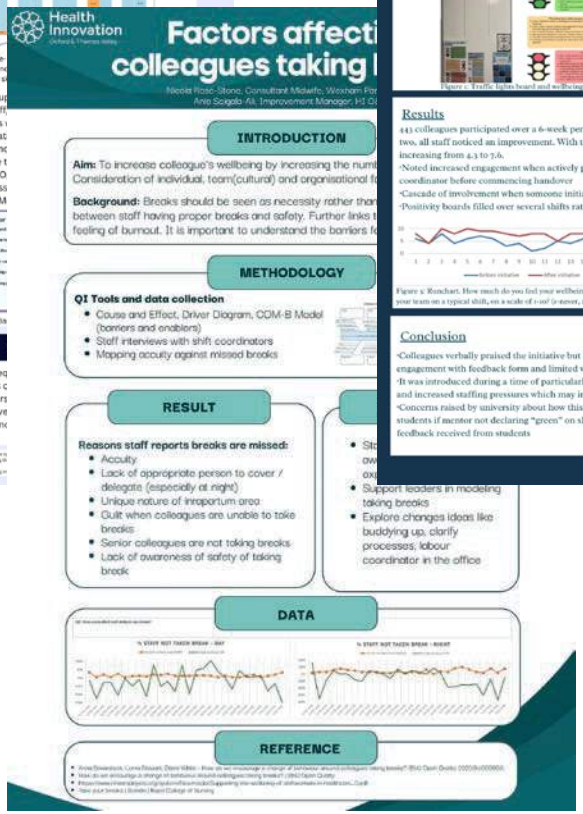
ACCOUNTABILITY

Discussions highlighted a reluctance among staff to take shared responsibility for collective problem-solving, with tasks often being deferred or passed on when they were perceived as undesirable.

PROCESS CONCERNS

Concerns were raised about processes and their efficiency. For example, identifying and contacting the appropriate team member for a home birth. Inefficiencies in such processes were reported to result in wasted time.





Analogue to digital

Treatment to prevention

Avoiding Brain injuries in Childbirth (ABC programme)

Avoiding brain injury in childbirth is well evidenced. Avoidable intrapartum brain injury can have devastating consequences for babies and their families, along with lifetime impacts for health and care services. The Avoiding Brain Injury in Childbirth (ABC) programme has its origins in a call for action by the Treasury in 2018 on the costs of litigation associated with avoidable brain injury.

Developed and piloted over three phases spanning 2021-2025, the ABC improvement programme was commissioned by the Department of Health and Social Care. It has been led by the ABC Collaboration, comprising the Royal College of Midwives (RCM), and the Royal College of Obstetricians.

The programme is expected to reduce the unwarranted variation in outcomes across England.

By narrowing this gap, it will support the majority of maternity units to achieve outcomes comparable to those currently attained by the highest-performing 20%. The reduction in the number of children born with Cerebral Palsy which could reduce litigation costs by £860 million - £1.4 billion per year.

Key deliverables

Ensure the effective training and implementation of impacted fetal head, intrapartum fetal deterioration in line with the ABC approach to all sites in Health Innovation Network geography and provide clinical, safety, implementation and improvement support.

Programme ambitions

To reduce avoidable brain injuries in childbirth by March 2027 through improving clinical practice, communication and care for women and families and result in better outcomes and experiences. The programme is designed to help maternity staff improve clinical practice of two significant contributors to avoidable brain injury in childbirth:

- Detection and response to suspected intrapartum fetal deterioration (IFD).
- Management of the obstetric emergency of impacted fetal head at caesarean birth (IFH).

Impacts for ABC

Progress to date
(programme commenced end of Q2):

- In one quarter we have established a national clinical faculty, creating expert capacity to support implementation, capability building and improvement across maternity services.
- 672 clinicians trained, strengthening local capability to reduce avoidable brain in injury in childbirth.
- All 15 PSCs have engaged with 100% of maternity sites and programme mobilised.

672 ABC
clinical staff trained

Training builds the infrastructure and supports sustainability

Case study 1:

IMPERIAL COLLEGE HEALTH PARTNERS

Reducing avoidable brain injury in birth: a system-wide approach

Approach: investing time in building relationships with individual Trust teams and understanding local context, created strong local ownership of the programme. This collaborative approach has generated system-wide enthusiasm for adoption and spread, supporting more consistent implementation across maternity services.

Results:
The programme started to reshape the management of impacted fetal head across North West London. With training delivered in three trusts, and the fourth soon to follow, we've consistently received strong engagement and enthusiasm from staff.

Read full case study on page 39.

Case study 2:

Health Innovation Wessex

Importance of training for impacted fetal head

Approach: Hands on practical learning.

Results: Increased confidence.

Read full case study on page 40.

Implementation in practice: Reducing avoidable brain injury in birth, a system-wide approach

(North West London)

IMPERIAL COLLEGE HEALTH PARTNERS

Background:

- Through national implementation, the ABC programme aims to strengthen clinical practice and improve communication and care for women and families, leading to better outcomes and experiences.

Project aims:

- Reducing variation in obstetric emergency response for impacted fetal head (IFH) between Trusts.
- Embedding evidence-based national guidelines and training into everyday maternity practice.
- Improving safety for birthing people and babies by reducing the risk of avoidable brain injury.

Method:

Our approach to the ABC programme focused on ensuring that each Trust received a practical, context-specific learning experience that strengthened their capability to manage IFH. We began by working closely with local training leads to understand existing training models, identify variation in practice, and understand where IFH training could add the greatest value.

Building on this foundation, we delivered Tier 2 'Train the Trainer' sessions across NWL, bringing obstetricians and midwives together to explore updated approaches to IFH management and to familiarise themselves with the new clinical algorithms. These sessions prioritised multidisciplinary discussion, and confidence-building in recognising IFH as a time-critical obstetric emergency.

By investing time in building relationships with individual Trust teams and understanding local context, we created strong local ownership of the programme. This collaborative approach has generated system-wide enthusiasm for adoption and spread, supporting more consistent implementation across maternity services.

Impact:

The programme has already started to reshape the management of IFH across NWL. With T2 training delivered in three Trusts, and the fourth soon to follow, we have consistently received strong engagement and enthusiasm from staff. The training clearly resonated, with average confidence increasing from 3.35 pre-training to 4.5 post-training, and participants consistently valuing the hands-on format.

> **"The team found it very helpful and engaging. They particularly valued the opportunity to practice delivering an impacted fetal head, including vaginal disimpaction and breech delivery via caesarean section. The session was very interesting, and the practical elements supported learning and confidence in managing these complex scenarios."**
>
> – Lead Midwife for Practice Development Chelsea & Westminster NHS Foundation Trust

Implementation in practice: The importance of training for impacted fetal head

Health Innovation Wessex

IFH T1 training 6th February 2026

Training sessions: 2x half-day sessions
Facilitation: 3x clinical faculty
Attendance: 27x resident doctors (ST1 - ST7)
Observation: IFH QA Handbook v4 completed

Feedback survey

Response rate: 19x responses (70%)

Most useful:
- Hands-on / practical learning of specific manoeuvres.
- Use of master algorithm and communication exercises.
- Expert feedback / discussion with the clinical faculty.

Perceived confidence (after the session):
- 11x much more confident
- 7x slightly more confident

95% of respondents reported improved confidence in managing impacted fetal head following the session

"Excellent explaining and then practical application with the role play scenario."

"Having hands on today on IFH gives me confidence in doing it in real life."

"This was really excellent, thank you. So, so important especially with rising section rates."

Health Innovation Network

Local change, national impact

Beyond programme delivery:

Innovation Discovery and System Leadership

The Patient Safety Commission is delivered by the 15 health innovation networks

Beyond programme delivery: Innovation Discovery and System Leadership

Alongside delivery of nationally commissioned patient safety improvement programmes, the Patient Safety Collaboratives have supported NHS England to test, refine and inform future policy, programme design and implementation approaches.

Through pilot programmes, discovery work and system-level improvement support, the PSCs have demonstrated their ability to:

- Test and evaluate new approaches before national implementation.
- Generate insight to inform policy development and future programme design.
- Support local systems to apply and adapt improvement methodologies to complex safety challenges.
- Build capability and leadership across systems, enabling sustainable improvement.
- Examples include delivery of Martha's Rule pilot sites, testing implementation approaches for Patient Safety Incident Response Framework (PSIRF) in general practice, exploring oversight arrangements within Integrated Care Boards, supporting application of the PIER framework at system level, and providing national leadership and coordination for the Medicines Safety Improvement Programme to the PSC.
- This work demonstrates the PSCs' unique role as a national improvement infrastructure that can rapidly support innovation, learning and implementation across the NHS.

Health Innovation Network

Local change, national impact

Innovation and Testing: Martha's Rule

- Testing in Maternity and Neonatal Services
- Testing in Emergency Departments
- Testing in Community Hospitals
- Testing in Mental Health Settings

The Patient Safety Commission is delivered by the 15 health innovation networks

Piloting in Emergency Departments (EDs)

Testing the feasibility and practical application of Martha's Rule in ED settings to inform national implementation plans

This work was led by Health Innovation Yorkshire & Humber (HIYH) on behalf of the 15 Patient Safety Collaboratives.

Pilot summary

- Worked with 7 Trusts, one from each region. All have remained well engaged, have shared their challenges, ideas for change and data.
- Site learning was supported through a steering group, peer to peer sessions (Learning Community) and 1:1 coaching calls.
- Regular Learning Community sessions were held with members across England. Any sites interested in the work could participate, even if they were not a formal pilot site.
- Captured regular insights to inform pilot direction: 2 Lighting reports, an interim report (April 26), 4 case studies, data and insights from Martha's Rule calls in the ED.

End of year insights and learning

- Getting early staff engagement, prior to implementation of Martha's Rule, is crucial. Particularly between critical care, ED and senior managers.
- Patients in ED waiting rooms are at risk of physical deterioration. Martha's Rule could benefit this cohort of patients and their families.
- Thought needs to be given to ways of triaging calls. As part of this work, it is useful to work with the ED's High Intensity User Teams to transfer their learning to Martha's Rule.
- It is possible to implement Martha's Rule into EDs, However, one size does not fit all. It is important for each site to carefully design their escalation models and align to their existing managing deterioration processes.
- Non-clinical ED staff play a crucial role in advocating for patients and spotting deterioration. Martha's Rule can enable their voice to be heard.
- Based on this pilot, Martha's Rule will now be spread to all EDs in England in 26/27.

Piloting in Mental Health Settings

Testing the feasibility and practical application of Martha's Rule in Mental Health Settings to inform national implementation plans

This work was led by Health Innovation Oxford and Thames Valley (HIOTV) on behalf of the 15 Patient Safety Collaboratives.

Pilot summary

- Nine mental health Trusts took part in the pilot.
- HIOTV held ten Community of Practice events and over sixty 1:1 coaching sessions with individual Trusts.
- Mental Health Trusts found applying Martha's Rule challenging as they do not have access to physical health response specialist teams (equivalent to Acute Trusts' Critical Care Outreach Teams) and Trusts typically cover a large geographical area and many diverse sites.
- Despite challenges, Trusts continued to explore and pilot a range of innovative ideas and approaches, frequently supported by co-production from service users.

End of year insights and learning

- All 9 Trusts actively engaged in the project and committed to piloting components of Martha's Rule.
- 1 Trust piloted all 3 components.
- 3 Trusts are piloting at least 1 component.
- 2 further Trusts plan to start piloting early in 26/27.
- Co-production (through the Community of Practice) of key considerations and a set of principles.
- Extension given to the pilot to allow for more time to test and better understand if Martha's Rule can be spread to all Mental Health Settings in England whilst maintaining fidelity to the model.

Piloting in Community Hospitals

Testing the feasibility and practical application of Martha's Rule in Community Hospitals to inform national implementation plans

This work was led by Health Innovation East Midlands (HIEM) and Health Innovation West Midlands (HIWM) on behalf of the 15 Patient Safety Collaboratives.

Summary of progress

- Selected, onboarded and tested with 8 Trusts (22 sites). To ensure that a breadth of learning could be captured, the sites included a variety of different settings, independent review provisions, maturity and patient cohorts.
- Bespoke 1:1 support for Trusts on their implementation journey, including support at project and working groups.
- Hosted numerous 'Community of Practice' sessions for Trusts to share learning and to provide a safe space for collaboration and discussion.
- Ran a "Soft Signs" webinar to ensure that soft signs recognition was embedded as part of their Martha's Rule implementation journey, under a holistic approach to deterioration.
- Produced a data collection tool for community metrics, aligned to the national acute data minimum dataset, with monthly data being collected from Trusts.
- Presented the programme at national community and Martha's Rule Boards to keep key stakeholders updated and engaged.

End of year insights and learning

- Extension given to the pilot to allow for more time to test and better understand if Martha's Rule can be spread to all Community Hospitals in England whilst maintaining fidelity to the model.
- Identified an opportunity to strengthen the understanding of escalation call activity (low) and proportionality to interpret low call volumes within community inpatient settings. Using metrics such as occupied bed days, admissions etc. This can be compared with equivalent rates from acute hospitals. Establishing this proportionality will clarify whether low numbers reflect a genuine lower need or signal under-utilisation of Martha's Rule Calls, informing the need for targeted awareness and engagement efforts.
- An opportunity to improve continuity of care specifically from acute to community has been identified. Further testing will look at including the Patient Wellness Question as part of the pro-forma to support with handover.

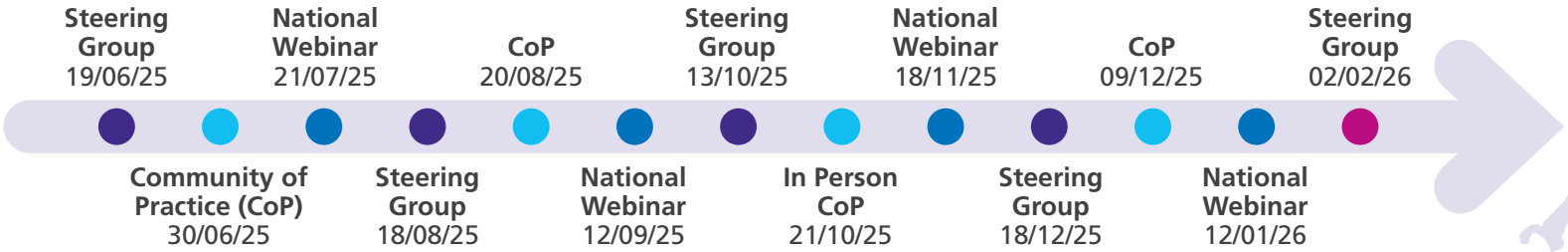
Pilot in Maternity and Neonatal Services

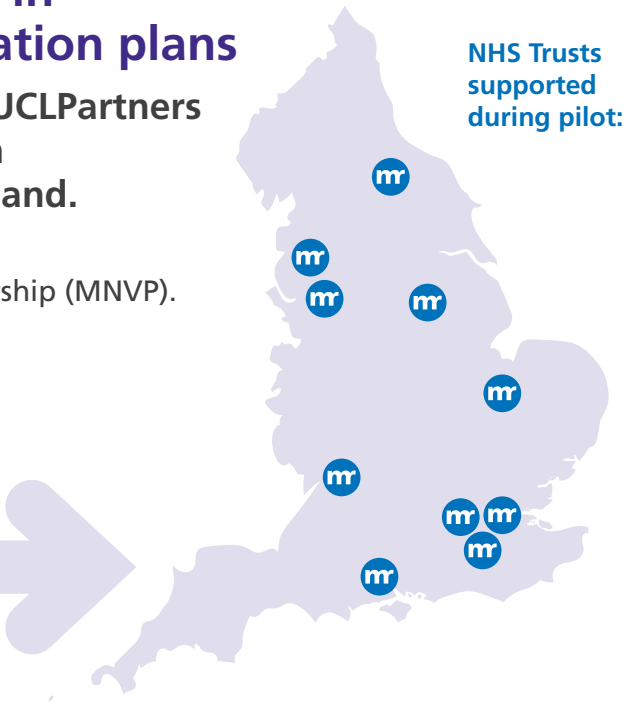
Testing the feasibility and practical application of Martha's Rule in Maternity and Neonatal Services to inform national implementation plans

This work was led by Health Innovation North East North Cumbria (HINENC) and UCLPartners on behalf of the 15 Patient Safety Collaboratives. They worked together to test in 15 Maternity and Neonatal settings, located in 10 different NHS Trusts across England.

Summary of pilot

- A steering group was established with key stakeholders including Maternity & Neonatal Voices Partnership (MNVP).
- A series of webinars were held and were open to all NHS Trusts in England.
- A 'Community of Practice' was established to bring pilot sites together to share and learn regularly.
- One-to-one tailored coaching and quality improvement support was given to all pilot sites.





End of year insights and learning

- There was 'no one size fits all' solution. Sites successfully implemented Martha's Rule by aligning it with existing escalation and safety-netting processes.
- Stronger cross-team collaboration (e.g. with Critical Care Outreach Teams) supported more integrated ways of working.
- There was no evidence of 'queue jumping' which was feared by some.
- Quality improvement testing supported safe, staged implementation
- Feedback from MNVP and NHS staff informed a review of existing national communication materials after opportunities to strengthen the perinatal perspective were identified
- Based on this pilot, Martha's Rule will now be spread to maternity and neonatal settings in England in 26/27

Health Innovation Network

Local change, national impact

Improvement Design and Development: PIER

The Patient Safety Commission is delivered by the 15 health innovation networks

Managing Deterioration: PIER

Prevention, Identification, Escalation, Response to physical deterioration, through better system co-ordination as part of safe and reliable pathways of care.

Health Innovation
WEST MIDLANDS

The PIER approach will enable the effective management of acute physical deterioration in health and care and will apply to all conditions, clinical settings and specialities.

The PIER approach views deterioration as a whole pathway which is supported by systems rather than only advocating a single strategy for identification.

Acute physical deterioration is the rapid worsening of a patient's condition.

It can be identified from changes in physiology, such as respiratory rate, blood pressure or consciousness, or more subtle signs, such as not eating and a patient or their family's concerns and observations around wellness, mental status or behaviour.

Deterioration can occur in any health and care setting and is the common pathway in all emergency admissions, prolonged illnesses and deaths.

PIER stands for:

- **P**revention: planning ahead of any episode of deterioration to stop what is preventable, considering indicators of risk and patient choice.
- **I**dentification: tools and methods to identify when deterioration is occurring in a standardised way.
- **E**scalation: timely escalation of care when deterioration has been identified using standardised communication tools.
- **R**esponse: timely, appropriate and effective response to escalation of the deteriorating patient.

PIER programme expected outcomes

PSCs to continue supporting their systems to work through the improvement toolkit, focussing on improving the pathway(s) that the mapping phase identified as being amenable to improvement and to work with and support system stakeholders to develop spread and sustainability plans.

Health Innovation West Midlands continue to support the development of the PIER framework on behalf of the 15 Patient Safety Collaboratives.

Scope and Approach

NHS Black Country Integrated Care Board

Accelerator Site

1

Integrated Care Systems

18

Regions

5

List of systems and regions involved

- 11 Integrated Care Boards in Midlands (Midlands region)
- Kent & Medway ICB (South East region)
- Sussex ICB & Surrey Heartlands ICB (merging 1 April 2026)
- North London ICB (London region)
- Cornwall and Isles of Scilly ICB (South West region)
- Blackpool Teaching Hospital NHS Foundation Trust (NW region)
- Warrington & Halton Teaching Hospital NHS Foundation Trust (NW region)
- HM Prison Services

Accelerator site

Black Country ICB was selected as the Accelerator Site.

In the context of limited national programme funding, their organisational readiness, dedicated programme leadership/resources, and capacity to act as a pathfinder for wider system adoption positioned them ideally to generate learning, refine the model, and support subsequent spread to other regions.

Support to other systems

Less intensive support was provided to systems across and beyond the Midlands. Intelligence gathered through PSCs in the Health Innovation Network identified additional organisations undertaking elements of PIER independently outside of the Midlands. This included smaller-scale initiatives such as those at Blackpool Teaching Hospitals.

However, unlike the accelerator site, these systems did not have comparable dedicated resource for PIER, which represented a considerable limitation and contributed to slower progress. Consequently, support varied and focused more on enabling organisations with readiness to follow the Black Country's learning trajectory, adapting insights to their local needs.

National PIER Learning Event

Midlands Deterioration Network

Whole Systems Approach

1:1 Support to ICBs

Sharing of learning particularly from the accelerator site

Whole system deterioration dashboard

Black Country Impact

FREED-PIER tools are now well embedded with care homes within the Black Country

Working with ICB Clinical Lead Networks within palliative and end of life care (PEoLC), Frailty and ReSPECT, including voice of social care and co-developing a system deterioration strategy

20%
Reduction in ED attendances from care homes (2023 fewer attendances)

£336,331.84*
Non-cost saving benefit from reduction in ED attendances from care homes

*60% optimism bias

Place-based initiatives - completing 72-hour reports to identify learning, areas for improvement

98%
of residents passing away in their preferred place of care within nursing homes

Linked in with Martha's Rule as part of a wider approach to managing deterioration with regular ICS Martha's Rule groups

Hereford and Worcestershire ICB

Other ICBs/systems also implemented PIER to a more limited degree compared to the accelerator site, and this was dependent on organisational readiness and resource available.

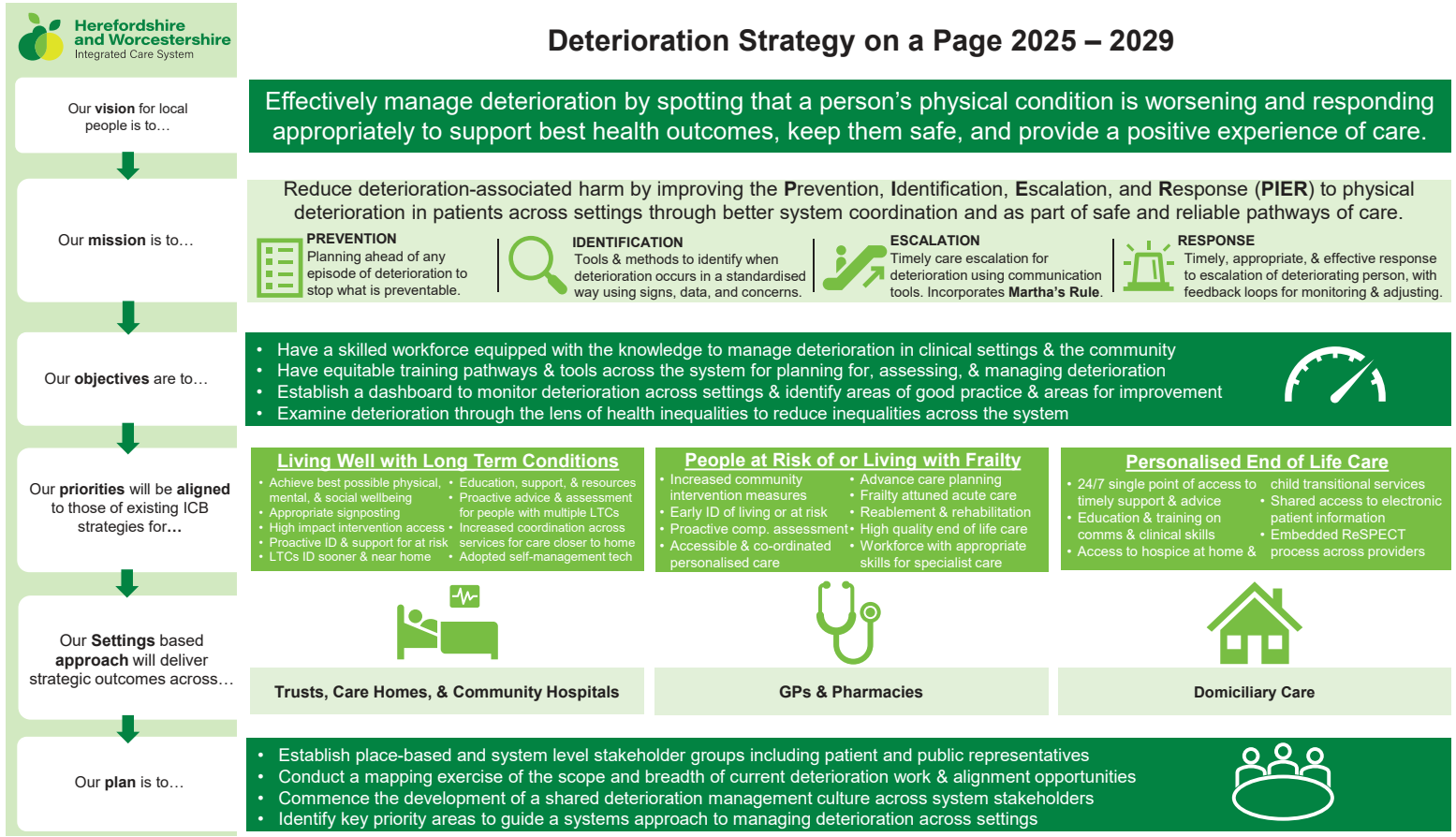
Herefordshire & Worcestershire ICB has been the most successful system in following in the footsteps of the accelerator site/ Black Country's approach.

They have especially benefitted from the sharing/learning from Black Country around:

- Black Country deterioration governance structures
- Black Country deterioration dashboard
- Black Country System Deterioration Strategy.

Herefordshire & Worcestershire ICB has:

- Conducted two place-based workshops to scope and identify what's working well in the system/ where the priority areas are
- Created a "Deterioration Plan on a Page 2025 - 2029"
- Drafted an ICS deterioration strategy
- Linked in with their cluster ICB (Coventry & Warwickshire ICB) as part of deterioration meetings
- Conducted a scoping exercise of the Black Country deterioration dashboard to understand metrics/ data flows that can be captured in their own system.



Future of PIER

Learning

Overall, learning from the programme has highlighted both progress and persistent challenges across systems.

Although there are pockets of good practice, and growing emphasis on soft signs, variation remains the dominant theme.

Addressing system fragmentation, improving shared language and data flows, building workforce capability, and strengthening holistic approaches will be essential for embedding the PIER model consistently and effectively. As well as this, system challenges leading to instability and uncertainty, greatly hinders capacity to implement PIER effectively, slowing or even halting progress in some cases.

A coordinated, cross-system approach, supported by shared data, cultural change, and sustained programme management will be key to unlocking the full potential of PIER and improving patient outcomes.

Requirements for PIER implementation

- System ownership and integration of deterioration/PIER into governance structures. Deterioration/PIER is so broad that unless there is explicit inclusion in structures, it can get "lost"
- Dedicated system deterioration leads/project support/analytics support to support data dashboard/funding.
- Engaged steering group with representation and buy-in from each part of the system.
- Integrated system plan that explores different levels (national/regional/local) outlining roles and responsibilities of different providers/stakeholders.

Health Innovation Network

Local change, national impact

Leadership and Coordination: Medicines Safety

The Patient Safety Commission is delivered by the 15 health innovation networks

National Patient Safety Improvement Programmes

National Programmes

Helping people with a learning disability, at risk of behaviour that challenges, to avoid harm from psychotropic medicines (2025-2026)

Health Innovation East Midlands and **Health Innovation West Midlands** were jointly commissioned as lead Patient Safety Collaboratives (PSCs) to collaborate with NHS England (NHSE) to deliver the national Medicines Safety Improvement Programme (MedSIP) 2025-2026. It uses a 7-phase whole system approach to change.

We delivered...

Shared learning nationally

- Organised five successful National Action and Learning Collaborative webinars.
- Hosted a national Innovation Exchange to showcase 10 innovations to 260 attendees.
- Shared learning across all 15 PSCs.
- Developed FutureNHS site to share resources.

Developed data, measurement and insight

- Co-developed two national outcome measures with supporting clinical system searches, standard operating procedures and governance documents.
- Provided analytical and technical expertise to build national dashboard and visualise data.

Co-ordinated and supported the network

- Provided 1:1 coaching for PSC leads aided by MS Teams, bulletins, and ad-hoc support.
- Created quality resources to support local delivery.
- Enabled use of the whole system approach to change, using a neighbourhood delivery model.

Visible, collaborative programme leadership

- Worked with NHSE (programme and STOMP/STAMP teams), PSCs, CDRC, Royal College of Psychiatrists and others to align work and provide oversight.
- Raised national visibility through communications and award and event submissions.

that created...

- A national learning and support infrastructure across 15 PSCs.
- National PSC support enabled 22 systems to progress through the Whole system approach and lay the foundations for high-quality improvement action next year.
- The first national psychotropic outcome measures of their kind.
- A national data dashboard with baseline data to drive local and national improvement and model change.
- A well-organised FutureNHS website repository, giving easy access to credible programme resources.
- Ongoing collaboration with expert stakeholders, leading to one peer-reviewed publication and a second in progress.
- Strengthened alignment between local delivery and the national programme approach.

which had the impact of...

- Systems across England have co-developed a draft action plan and are ready to deliver measurable improvement.
- First national antipsychotic quality improvement dataset, giving NHSE, PSCs and systems clearer visibility of the target population.
- Early signs of impact from prescribing rate changes, with provisional modelling **suggesting 21 severe harms avoided** up to October 2025.

- Strengthened learning and innovation infrastructure, accelerating the spread of effective approaches and reducing duplication.
- Consistent national direction and understanding, with swift resolution of PSC and system queries.
- Strong collaboration, improving the credibility and rigour of programme outputs.

Next steps:

Through 2026/27 we will continue to support delivery of the Medicines Safety Improvement Programme (MedSIP) working collaboratively with partners to create the conditions to enable whole system change. This will drive quantifiable improvement in quality of life and reduction in medicines related harm for people with learning disability at risk of behaviour that challenges.

Health Innovation Network

Local change, national impact

Innovation and Testing: System Safety

- **Testing In General practice**
- **Understanding oversight in ICBs**

The Patient Safety Commission is delivered by the 15 health innovation networks

Systems Safety

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

[NHS England » Patient Safety Incident Response Framework]

Key deliverables

- Enabling supportive system oversight of PSIRF.
- Support ICBs to deliver the role set out in the PSIRF Oversight Roles and Responsibilities Specification, as well as supporting its iteration and improvement.

Expected outcomes

The lead PSC will have implemented the test pilot of PSIRF implementation in interested General Practices.

The Lead PSC will enable each ICB to provide oversight role to systems based on the PSIRF principles and guidance.

Gathering local insights and learning

Health Innovation West Midlands (HIWM) and Health Innovation East Midlands (HIEM) are leading the PSIRF Oversight programme to support ICBs on behalf of the 15 Patient Safety Collaboratives

In March 2025, NHS England commissioned a one-year programme to support ICBs in delivering the role set out for supportive system oversight under the PSIRF. HIWM and HIEM delivered a defined programme of work to support implementation, while also testing, iterating and refining the national Oversight Roles and Responsibilities Specification, as informed by emerging learning.

Navigating the evolving national landscape required a deliberately adaptive and intelligence-driven engagement strategy in the programme delivery approach. With the roles of ICBs, regional NHS England teams, provider partners and the national PSIRF leadership shifting throughout this period, the programme could not rely on a single engagement route. Instead, it adopted a tiered, tailored and dynamic model designed to generate the depth and quality of insight needed from each stakeholder group. Through targeted engagement and psychologically safe insight-gathering, the programme surfaced system-level patterns, inconsistencies, good practice and risks in PSIRF oversight.

Close partnership with ICBs, providers and national PSIRF leads ensured recommendations were grounded in lived experience. This created shared visibility of where clarity, support or intervention would have the greatest impact, enabling more focused and proportionate national and regional action.

As a result, the programme delivered credible, practical insight that improved alignment between national expectations and local delivery, and supports more consistent, learning-focused oversight across systems.

39 out of 42 ICBs across England have been able to engage with HIWM and HIEM in this work.

As well as regional NHS England PSIRF leads, and over 20 provider organisations across a range of specialities.

Sharing all our linen: How Lancashire & South Cumbria built a system of trust, transparency and joint learning under PSIRF

The Lancashire and South Cumbria system began its PSIRF journey from a previously fragmented landscape where the Clinical Commissioning Groups and Providers had worked in isolation. An environment where there was minimal shared learning, and a culture where mistakes stayed behind organisational walls. Recognising the shift demanded by PSIRF and the National Patient Safety Strategy, the ICB built a diverse patient safety team, prioritised relationship-building, and created inclusive spaces where providers (NHS and private) could learn openly and safely together. Over time, this evolved into a mature shared learning ecosystem, where joint Patient Safety Incident Investigations became routine and cross-provider collaboration strengthened outcomes for patients and families.

Through determination, inclusivity, and psychological safety, the integrated care system transformed its culture. Families, Coroners, and Providers now see the difference: joint investigations, transparent communication, and improvements rooted in shared accountability.

> **Basically, we're happy to share all our linen now, whether it's dirty or clean.**
>
> Caroline Marshall
> Lancashire &
> South Cumbria ICB

> **Sometimes it's another Trust that's got the solution to your problem.**
>
> Sarah Harrison
> Lancashire &
> South Cumbria
> Foundation Trust

Challenge:

Deep-rooted organisational silos where organisations operated independently with little collaboration or shared understanding. The mindset of not exposing problems ("dirty linen") blocked open learning. Fear and uncertainty about PSIRF where providers found early implementation "frightening and daunting," unsure how to engage clinicians or redesign processes.

What we did:

- Made relationship-building a formal system priority.
- Established the ICB PSIRF Implementation Group.
- Evolved into a Community of Practice and then a Shared Learning Forum.
- Created and adopted Joint Working Principle.
- Started conducting truly joint Patient Safety Incident Investigations where mental health, acute, and private providers now work together on investigations, reducing duplication and improving insight.
- Built a culture of proactive cross-provider problem-solving.

Outcome:

- A **mature, psychologically safe learning culture** where providers now willingly "share all their linen, dirty or clean."
- A **system-wide focus on collective learning,** not organisational defensiveness.
- Better understanding of whole patient journeys through **a cross-pollination of expertise.**
- **Stronger early-stage communication -** providers now engage in earlier shared conversations about patients, reducing gaps, misunderstandings, and missed opportunities.

Resources:

Full webinar recording and access to the slides can be found here: FUTURESNHS

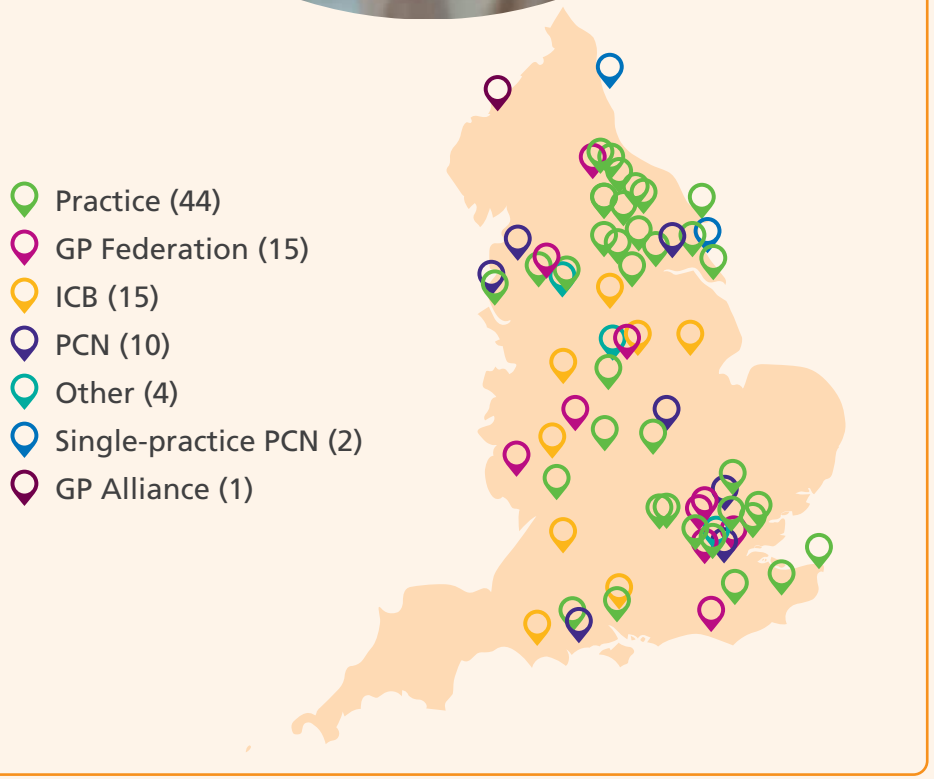
PSIRF in General Practice

HIN South London are leading the pilot to introduce the Patient Safety Incident Response Framework (PSIRF) into General Practice.

16 pilot teams made of 15 ICBs, 10 PCNs, 15 GP Federations, hospices, acute trusts, community health providers and 44 GP practices joined the second year of testing.

Key updates and achievements

- Developed **planning templates and guidance** to help organisations map current practice and adapt and improve patient safety processes.
- Developed a **logic model** with stakeholders and participants to inform the plan for an evaluation of the pilot.
- **Linked organisations** within geographical regions together.
- Delivered 9 check-in **webinars** to support development of ideas and share common challenges, and 2 learning webinars covering LFPSE and CQC roles in patient safety.
- Conducted a formative **mixed-methods process evaluation** to assess how PSIRF is interpreted and applied in general practice to understand the motivations for transitioning to PSIRF; the challenges and barriers and the progress being made in each of the steps.
- Created **a guide for general practice** to map where their patient safety systems and processes are - and identify what steps can be taken to bring them closer to following PSIRF.



Pilot in General Practice

Learnings

At practice level, dedicated roles and leadership, existing cultures of transparent incident reporting, and streamlined incident reporting systems and processes are key enablers to adoption. Constrained staff capacity and lack of patient safety expertise are key barriers.

At a PCN/federation level, patient safety expertise and leadership, centralised governance and coordination, and inter-organisation sharing and learning facilitate adoption. However, there can be variable engagement across practices, hesitancy to share incidents, and limited capacity for coordination.

At a system level, ICB supportive oversight can provide valuable support and coordination, particularly around aggregating system-wide incident data and feeding back across the system. CQC endorsement, national training and resources can also drive and support adoption. Significant barriers include a lack of accessible, affordable training, challenges with Learn From Patient Safety Events (LFPSE) relevance and feedback. A notable and significant risk to adoption is ongoing ICB restructure and related risks to the provision of supportive oversight.

What the pilot teams said

This isn't a blame exercise; this is actually just to investigate what's happened and look at the system surrounding the incident.

- GP Partner, PCN

Sharing learning more openly has helped increase awareness among staff of the importance of patient feedback and safety processes.

- Practice Manager, GP Surgery

Health Innovation Network

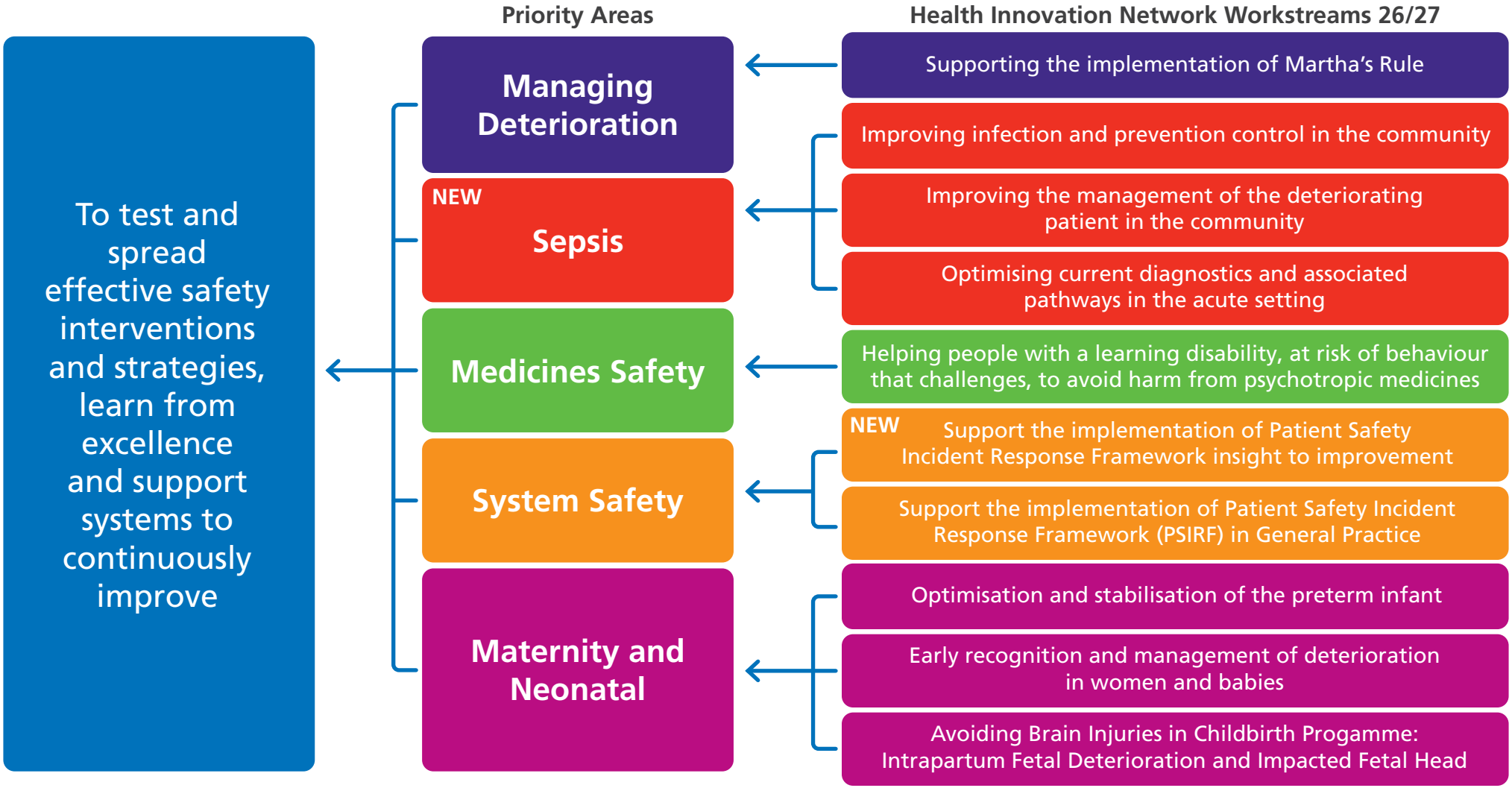
Local change, national impact

Our programmes for 2026/2027

The Patient Safety Commission is delivered by the 15 health innovation networks

NHS England Patient Safety Improvement Programmes 2026/27

Our commission for 2026/27 includes two new programme areas: Managing Sepsis and, building on the work of the previous pilot, PSIRF.



Katie Toms
HI Kent Surrey Sussex
Kate.toms3@nhs.net

Jan Scott
HI West of England
janet.scott26@nhs.net

Stuart Kaill
HI Manchester
stuart.kaill@healthinnovationmanchester.com

Kursoom Khan (Kay)
HI East Midlands
Kursoom.Khan@nottingham.ac.uk

Katherine Edwards
HI OTV
katherine.edwards@healthinnovationoxford.org

Maxine Sleath
HI North East and North Cumbria
Maxine.sleath@healthinnovationnenc.org.uk

Jodie Mazur
HI West Midlands
jodie.mazur@healthinnovationwm.org

Caroline Angel
HI East
caroline.angel@healthinnovationeast.co.uk

Jenny Hamer
HI Yorkshire & Humber
Jenny.hamer@yhahsn.com

Jo Murray
HI Wessex
jo.murray@hiwessex.net

Catherine Dale
HIN South London
catherine.dale3@nhs.net

Amanda Andrews
HI North West Coast
Amanda.Andrews@healthinnovationnwc.nhs.uk

Shakti Dookeran
Imperial College Health Partners
Shakti.dookeran@imperialcollegehealthpartners.com

Sally Hedge
HI South West
Sally.hedge@healthinnovationsouthwest.com

Valentine Karas
UCL Partners
valentina.karas@uclpartners.com

Health Innovation Network
Local change, national impact

Contact us

For more information about our work, visit thehealthinnovationnetwork.co.uk

You can also follow us on social media:

The Health Innovation Network

@TheHealthInnovationNetwork

Or find your local health innovation network

Patient safety - The Health Innovation Network