Maternity patient safety

Management of risk

Patient safety within maternity is led by the Patient Experience Team. In addition to conducting investigations into patient safety incidents the team coordinate and ensure the developed actions from each have been completed. Recent additions to the team include the appointment of a Risk Lead Midwife who has begun to coordinate Datix reporting and action as well as a Risk Lead Consultant who provides appropriate expertise. It has been recognised that learning from incidents within maternity must be enhanced. The Maternity department have begun to explore different methods to enhance learning across the whole of the department.

Investigator training

SaTH has recently commissioned Consequence UK to provide training in effective investigation of risk. The training will provide clarity in what makes a 'good' and appropriate level of investigation and clarity in what is required of an investigator and their team. Such training will enhance the ability of the patient safety team within maternity to conduct high quality investigations.

NHSR Early Notification Scheme

NHS Resolution have identified some early indicators to incentivise improvements in maternity safety which are aligned with elements of the Royal College of Obstetricians and Gynaecologists' (RCOG) Each Baby Counts national quality improvement programme. It is now a requirement for trusts to report all maternity incidents occurring after 1 April 2017 which are likely to result in severe brain injury. NHSR plan to increase the level of support we provide to teams when these rare incidents occur. SaTH has commenced this work and will continue to report to the organisation.

Maternal and neonatal health safety collaborative

This is a 3 year national programme to support improvement in the quality and safety of maternity and neonatal units across England. The overall aim of the programme is to reduce the rates of maternal deaths, stillbirths, neonatal deaths and brain injuries that occur during or soon after birth by 20% by 2020 and 50% by 2030. All NHS trusts who provide maternity services in England are required to make measurable improvements in safety outcomes for women, their babies and families by exchanging ideas and best practice. The collaborative will help all maternity care providers and commissioners to:

- improve clinical practices
- reduce unwarranted variation
- report on how they are contributing to achieving the national ambition

SaTH was placed in wave 2 of the collaborative which is expected to roll out in April 2018.

Plan

SaTH Maternity will work with commissioners as well as patient representatives in order to improve the identification, investigation and learning outcomes from patient safety incidents.