ZEST Safety Incident Response Plan

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Introduction

This Patient Safety Incident Response Plan sets out how ZEST Midwives Ltd (hereafter referred to as ZEST), intends to respond to safety incidents over a period of 12 to 18 months. We will remain flexible and consider the specific circumstances in which safety issues and events occurred and the needs of those affected.

First, it is important to clarify contextual language nuances. In shaping governance and safety frameworks, we acknowledge that pregnancy and birth are normal physiological life events. Our approach, when establishing the principles of PSIRF into ZEST, reflects this understanding, ensuring respect for continuity of care models, prioritising autonomy, relational continuity, and respectful support, rather than reverting to medicalised or patient-based paradigms. Therefore, we avoid framing birthing women and people as patients.

ZEST is a unique, co-created initiative established to support truly autonomous independent midwifery practice and to facilitate access to physiological birth choices. ZEST champions continuity of care, which is a foundational principle in midwifery that empowers birth workers and enriches the birthing experience for families through a known and trusted relationship.

ZEST's primary mission is to ensure that independent midwives can continue to provide full-spectrum, evidence-based care with the essential safeguard of professional indemnity insurance and comprehensive midwifery training and support. ZEST facilitates access to specialist insurance at an appropriate level of cover, enabling registrant midwives to offer comprehensive and legally compliant care from pregnancy through to postnatal support.

Continuity of care in midwifery has been shown to improve safety outcomes for birthing women and people, including reduced rates of preterm birth, fewer interventions during labour, and higher satisfaction with the birthing experience. By supporting strong, trusting relationships between midwives and birthing women and people, continuity of care ensures that individual needs and preferences are respected and met throughout the birthing journey. This approach aligns with the principles of the PSIRF, which emphasises the importance of learning from safety events to improve care quality and outcomes. By integrating continuity of care with PSIRF, ZEST is committed to creating a safe, supportive environment where birthing women and people receive the highest standard of care, and midwives are empowered to provide it.

Our services

To ensure that the shape and structure of our PSIRF plan reflects the breadth and intricacy of services offered by our registrant midwives and MaMas (Mother and Midwife Assistant), we began by undertaking a comprehensive service mapping exercise. This process aimed to surface the full range of care provided, from standalone antenatal and postnatal support to full continuity of care that includes intrapartum services.

We recognised that midwives lead on varied models of care, with some offering support exclusively during the antenatal and postnatal periods, while others provide continuous care throughout pregnancy, labour, and birth. This diversity carries distinct safety considerations, particularly in relation to intrapartum transfers to hospital settings, and other safety events that may arise during labour and birth.

To inform our mapping, we engaged directly with midwives, birth workers and birthing women and people to gather insights into lived experiences, perceived risks, and areas of concern. We also reviewed historical safety data, including reported incidents and outcomes, compliments and complaints, to identify patterns and opportunities for improvement.

ZEST has a unique reporting Trigger Notification process for when birthing women and people wish for specific care plans, such as being supported to birth at home pre-37 weeks or beyond 42 weeks of pregnancy, or who wish to be supported at home to birth twins. There are also trigger notifications for maternity incidents; these include transfers into hospital from a planned homebirth, any obstetric or neonatal emergency, delays in care or in relation to a client's complaint. A high reporting culture is encouraged with immediate follow up on all Trigger Notifications with one of the Professional Midwifery Advocates (PMA) who work in the ZEST senior leadership team.

The result is a detailed service map that highlights key safety priorities across the continuum of care. This map underpins our PSIRF approach, enabling us to tailor incident response mechanisms to the specific risks and realities of each service type. It ensures that our plan recognises the unique contributions of registrant midwives and MaMas and the safety needs of the birthing families that they work with.

The service map has enabled us to identify and prioritise areas where safety risks are most likely to occur or where the impact of incidents may be greatest. We have highlighted services involving intrapartum care, emergency transfers, and management of clinical complications such as postpartum haemorrhage, recognising the time-critical nature of these events.

By contrast, maternity services focused solely on antenatal or postnatal care may present different safety considerations; these may include continuity of information, safeguarding concerns, or delayed escalation of new complexities/risk factors that arise. Our prioritisation approach reflects these nuances, ensuring that incident response processes are proportionate, situationally sensitive, and in line with the scope of care provided.

We are committed to supporting all registrant midwives and MaMas to engage meaningfully with PSIRF processes, regardless of the model of care they offer. This includes:

- Individualised guidance and support for registrant midwives and MaMas, recognising the diversity of their contractual arrangements.
- Clear pathways for incident reporting and reflection, designed to be accessible, supportive and non-punitive.
- Opportunities for shared learning through regular safety huddles, enabling registrants to contribute to and benefit from system-wide safety insights.

Defining our patient safety incident profile

To identify and agree on the safety issues that are specific to ZEST, we reviewed data to build a robust safety incident profile. This included analysing trigger notification incident reports and documentation audits. The timeframe of two years provided a comprehensive overview of safety incidents, allowing us to recognise recurring themes and develop targeted strategies to address these issues and to support the birth workers in their practice.

The services covered by our plan include antenatal care, intrapartum care, and postnatal support provided by our birth worker registrants. Each service was mapped to identify specific safety priorities and areas for improvement. Detailed guidance for these services is included in our plan, ensuring that all aspects of midwifery care are addressed and that our approach is tailored to the unique needs of each service.

The most common themes of safety events from ZEST's Trigger Notifications process are as follows:

- Postpartum Haemorrhage
- Intrapartum transfer: however, all transfers are reviewed via the Trigger Notification process and there is consistent evidence of dynamic risk assessment and action. Reasons for transfer include maternal wellbeing such as blood pressure issues or requirement for further pain relief (comfort measures), fetal wellbeing concerns, or prolonged second stage.

In terms of complaint themes, there have been two complaints that have been received at ZEST in the last two years that have cited communication issues between ZEST registrants and their clients.

Defining our patient safety improvement profile

Over the last few years, ZEST has developed its governance processes to gain insight from Trigger Notifications and feedback received, and this has fed into quality improvement activity. We will also continue to draw on guidance and feedback from national and regional level NHS bodies, partner providers and other key stakeholders to identify and define the quality improvement work we need to undertake.

Exclusive ZEST training

ZEST Midwives offers an exclusive training offer to birth workers. Our Training includes:

- Engagement and Enrolment Days - introduces participants to the ZEST team, values and support systems while covering verification, roles and responsibilities, collaborative learning, insurance access, and concludes with a wellbeing and relaxation session.
- Mandatory Practical Training: Safe & Skilled at Home: Community Birth Challenges - an interactive, PROMPT style training, in-person day designed to strengthen safe decision-making in community birth through experiential, scenario-based learning focused on situational awareness, human factors, and evidence-based practice.
- Level 3 Safeguarding - exclusive to ZEST, created through the lens of independent midwifery practice. Interactive day focusing on best practice and reflecting on shared experiences and professional insight.
- Equality, Diversity and Inclusivity (EDI) Support - At ZEST, we are dedicated to fostering an equal, equitable, and accessible environment for all birthing people, including our registrants and the diverse families they support.
- Calm and Confident Birth Practitioner Training - equips midwives with the skills, tools, and confidence to empower birthing people, promote physiological and fear-free birth, and support informed birth choices across home, MLU, and hospital settings.

Nursing and Midwifery Council (NMC)

We have worked with the NMC to offer a proposal of how to support Independent Midwives who are referred to the NMC.

Service Level Agreement for all registrants

The purpose of the Service Level Agreement (SLA) is to describe the key services ZEST provides and the quality standards that registrant midwives and MaMas can expect from ZEST in terms of service delivery. This Agreement sets out:

- the services provided to registrant midwives and MaMas,
- the overall standard of care that ZEST expects to be delivered through the services provided by self-employed independent midwives working with us,
- the expectations of registrant midwives and MaMas to operate within the agreed framework outlined in this agreement,

- a mechanism for resolving any problems relating to the delivery of the service or deviation from the agreement.

Service Level Agreement for collaborative working with NHS Maternity Units

This is a service level agreement (SLA) between the NHS and an independent Midwife who is registered with ZEST to provide a homebirth care package to offer personalised and continuous support. The SLA sets out the formal agreement between an NHS Trust and the registrant midwife. It details the governance of the arrangement, including responsibilities of both the registrant midwife and the NHS Trust, financial commitments, and escalation processes.

ZEST Kindness, Quality and Safety Collaborative (KQSC)

ZEST's senior leadership team is the Kindness, Quality and Safety Collaborative (KQSC) that works to a clear manifesto to support independent midwives and other maternity care professionals to collaborate and work together to assure continuity of care, and better outcomes for both birthing people and their newborns.

ZEST KQSC aims and values:

- ZEST KQSC influences collaboration in practice encouraging interdependence, shared ownership of goals, and flexibility.
- ZEST KQSC values the diversity of clinical expertise and appreciates how this affects improvement of maternity care and organisational effectiveness.

Our patient safety incident response plan: national requirements

Safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria (in NHS England's Never Events list 2018, updated 2021), for example, retained or lost clinical item (swab or instrument)	Patient Safety Incident Investigation (PSII)	Create local organisational actions and feed these into the quality improvement strategy
Maternal death	PSII or collaboration with local NHS Trust to contribute to an MNSI[1] (in line with national guidance)	Respond to recommendations as required and feed actions into Quality Improvement Strategy.

[1] Maternity and Neonatal Safety Investigation

Maternity and neonatal incidents meeting criteria for a MNSI	PSII or collaboration with local NHS Trust to contribute to an MNSI (in line with national guidance)	Respond to recommendations as required and feed actions into the quality improvement strategy
Safeguarding incidents in which: Babies, child and young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse / violence. Adults (over 18 years old) are in receipt of care and support needs by their Local Authority The incident relates to FGM, Prevent (radicalisation to terrorism); modern slavery & human trafficking or domestic abuse / violence.	Refer to local authority safeguarding lead.	Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.
Incidents in screening programmes	Facilitated Reflective Review (MDT reflective review or After Action Review (AAR)) completed locally	Refer to local Screening Quality Assurance Service for consideration of locally led learning response. See: Guidance for managing incidents in NHS screening programmes Managing safety incidents in NHS screening programmes - GOV.UK (www.gov.uk)

Our patient safety incident response plan: local focus

All safety events which have resulted in moderate harm or above will require a Rapid Incident Review (RIR) as a minimum to support the statutory Duty of Candour process, to ensure that we do not breach regulatory requirements.

Maternal safety event type	**Proposed ZEST Learning Response**	**Anticipated improvement route**
Maternal collapse (anaphylaxis, cardiac arrest, eclampsia, uterine rupture, amniotic embolus)	Rapid Incident Review (RIR) and escalation to local PSII as required	Create local safety actions and feed these into Quality Improvement Strategy
Maternal admission to ITU	RIR and escalation to PSIRF MDT Reflective Review with NHS Partner or local PSII as required	Create local safety actions and feed these into Quality Improvement Strategy

Massive Obstetric Haemorrhage - Blood loss >1000ml at a homebirth	Continuous case by case audit. RIR if omissions in care identified and escalation to PSIRF After Action Review (AAR) or PSII as required	Create local safety actions and feed these into Quality Improvement Strategy
Transfer in from home birth or Birth out of home or hospital	Continuous case by case audit. RIR if omissions in care identified and escalation to PSIRF AAR as required	Create local safety actions and feed these into Quality Improvement Strategy
Maternal postnatal admission to hospital	Continuous case by case audit. RIR if omissions in care identified and escalation to PSIRF AAR as required	Create local safety actions and feed these into Quality Improvement Strategy
Third or fourth degree tear	Continuous case by case audit. RIR if omissions in care identified and escalation to PSIRF AAR as required	Create local safety actions and feed these into Quality Improvement Strategy
Shoulder dystocia (review if harm to baby)	Continuous case by case audit. RIR if omissions in care identified and escalation to PSIRF AAR as required	Create local safety actions and feed these into Quality Improvement Strategy
Venous thromboembolism in pregnancy or <6/52 postnatal	Continuous case by case audit. RIR if omissions in care identified and escalation to PSIRF AAR as required	Create local safety actions and feed these into Quality Improvement Strategy
Documentation Wrong information that has led to harm or near miss where significant harm could have been caused	RIR and escalation to AAR as required	Create local safety actions and feed these into the Quality Improvement Strategy.
Medication Error in administration of medications resulting in moderate harm or above	RIR and escalation to PSII or AAR as required	Create local safety actions and feed these into the Quality Improvement Strategy.
Delayed Delivery in care Delay in care, treatment, or in an emergency situation resulting in harm or distress (moderate or above harm)	RIR and escalation to PSII or AAR as required	Create local safety actions and feed these into the Quality Improvement Strategy.
Communication • Monitor themes around communication failures • Monitor themes around information giving	Thematic analysis/AAR	Create local safety actions and feed these into the Quality Improvement Strategy.

Neonatal safety event type	Proposed ZEST Learning Response	Anticipated improvement route
Intrapartum Stillbirth	Collaborate and contribute to Perinatal Mortality Review Tool (PMRT) in collaboration with partner NHS Trust as required. Also collaborate with MNSI investigation with NHS Trust	Respond to recommendations and feed actions into Quality Improvement Strategy.
Early neonatal death	Collaborate and contribute to Perinatal Mortality Review Tool (PMRT) in collaboration with partner NHS Trust as required. Also collaborate with MNSI investigation with NHS Trust	Respond to recommendations and feed actions into Quality Improvement Strategy.
Neonatal death from 7 days up to 28 days	PMRT in collaboration with partner NHS Trust as required.	Respond to recommendations and feed actions into Quality Improvement Strategy.
Neonatal Neurological issue e.g. seizures, HIE, intraventricular haemorrhage	Collaborate and contribute to MNSI investigation in collaboration with partner NHS Trust as required.	Respond to recommendations and feed actions into Quality Improvement Strategy.
Any fetal loss (except termination of pregnancy)	PMRT in collaboration with partner NHS Trust as required.	Respond to recommendations and feed actions into Quality Improvement Strategy.
Apgars less than 7 @ 5 mins	RIR and escalation to PSII or AAR as required	Create local safety actions and feed these into the Quality Improvement Strategy.
Unexpected transfer of neonate to tertiary care	RIR and escalation to PSII or AAR as required	Create local safety actions and feed these into the Quality Improvement Strategy.
Undiagnosed fetal anomaly	RIR and escalation to PSII or MDT review as required	Create local safety actions and feed these into the Quality Improvement Strategy.
Term (>37 weeks gestation) admission to NICU	RIR and escalation to PSII or AAR as required	Create local safety actions and feed these into the Quality Improvement Strategy.
Birth trauma e.g. laceration, fracture, nerve injury	RIR and escalation to PSII or AAR as required	Create local safety actions and feed these into the Quality Improvement Strategy.
Severe neonatal infection (e.g., missed GBS)	RIR and escalation to PSII or AAR as required	Create local safety actions and feed these into the Quality Improvement Strategy.
Delay in detection and referral of jaundice resulting in pathological jaundice requiring admission, phototherapy and blood transfusion	RIR and escalation to PSII or AAR as required	Create local safety actions and feed these into the Quality Improvement Strategy.

ZEST Guidance for Harm levels

These maternity specific harm levels have been developed with reference to Learning From Patient Safety Events (LFPSE).

Moderate Harm Incidents Related to Maternity Care

Maternal

- Postpartum haemorrhage requiring hospital admission and blood transfusion with full recovery within one month
- Fourth degree tear
- Maternal infection following birth requiring admission, IV antibiotics and extended hospital stay

Neonatal

- Unplanned admission to NICU for short-term respiratory support or infection management
- Hypoglycaemia requiring admission, IV glucose but without neurological impact.

Psychological

- Significant distress caused by inadequate communication, lack of consent or perceived neglect – especially if it leads to anxiety, trauma symptoms, or delayed bonding.

Severe Harm Incidents Related to Maternity Care

Maternal

- Uterine rupture leading to emergency hysterectomy and loss of fertility.
- Severe postpartum haemorrhage resulting in multi-organ failure or intensive care admission.
- Sepsis due to delayed recognition or treatment, resulting in long-term health consequences.
- Eclampsia or stroke during pregnancy or labour, with lasting physical or cognitive impairment.

Neonatal

- Hypoxic-Ischaemic Encephalopathy (HIE) due to delayed recognition of fetal distress, resulting in cerebral palsy or other neurological disabilities.
- Shoulder dystocia with brachial plexus injury leading to permanent loss of arm function.
- Stillbirth or neonatal death following preventable delays in care or mismanagement.
- Psychological
- Birth trauma resulting in post-traumatic stress disorder (PTSD), especially when linked to poor communication, lack of consent, or perceived neglect.