NHS England

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Sent by email to:
Heads of Maternity at NHS Trusts
and NHS Foundation Trusts

Patient Safety Domain
Skipton House
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Email: patientsafety.enquiries@nhs.net

23rd March 2016

Dear Colleagues

Re: Learning from Never Events in gynaecology and maternity

As part of the work of NHS England's Women's Health Patient Safety Expert Group we are seeking to learn more from incidents and claims relating to retained vaginal swabs following a gynaecological or obstetric procedure.

As you will be aware, retained swabs after surgical intervention are one of the most common types of Never Event. Retained vaginal swabs continue to account for a third of all retained swabs, justifying a fresh look at this issue with a view to understanding where we might be able to make national improvements. Our analysis of incidents reported to the National Reporting and Learning System (NRLS) suggest certain underlying themes are contributing factors; these include human factors and procedural processes.

To help us get a better understanding of these incidents we would be grateful if you could send this letter and survey link to your maternity risk manager or the person you consider best placed to be able to complete this information. The survey can be accessed using the link below and should take no more than 30 minutes to complete. We would be thankful if you can respond by 18:00 on Friday April 29th 2016. The survey has received clearance via the NHS England Burden Assessment process.

https://www.engage.england.nhs.uk/survey/prevention-of-retained-foreign-objects/

Your response will only be used by NHS England for research and analytical purposes and will support us to determine possible recommendations and further interventions for reducing these Never Events. Individual information on trusts will not be passed to regulatory bodies and will be used solely for national learning. Any resulting recommendations will be fed back to clinicians through a number of

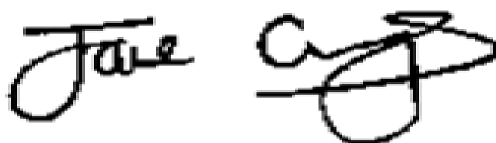
national forums, publications and resources. We will however, share any new recommendations we make with regulatory bodies to support future safety and quality improvement.

In addition, if your trust has developed any of its own initiatives around the prevention of retained vaginal swabs, we would be grateful if you can share details with us. We will then consider this for wider sharing to support other organisations in their own improvement work.

Please send information about your own existing or planned initiatives to Michele.upton@nhs.net; along with any queries you have in relation to this overall programme of work.

Many thanks for your help and your ongoing support in improving patient safety.

With best wishes,



Dr Mike Durkin
Director of Patient Safety

Jane Cummings
Chief Nursing Officer