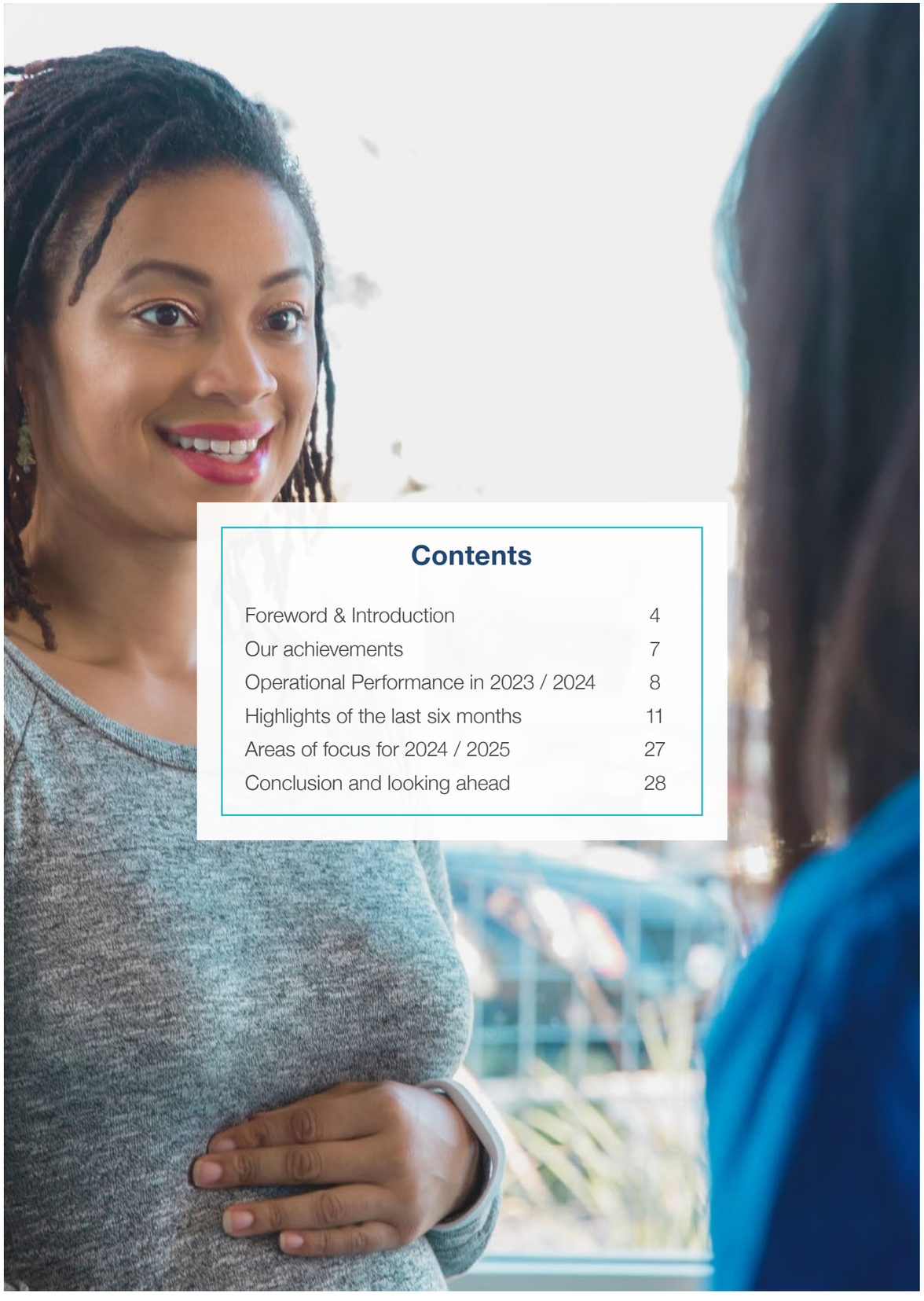
MNSI
Maternity & Newborn Safety Investigations

ANNUAL REPORT

OCTOBER 2023 / MARCH 2024

www.mnsi.org.uk



Contents

About MNSI

The Maternity and Newborn Safety Investigation (MNSI) programme carries out independent safety investigations related to NHS-funded maternity care in England that meet the criteria set out on our website.

Most harm in healthcare results from problems within the systems and processes that determine how care is delivered. Events are referred to us by the NHS trust where the care took place and, where an outcome meets the criteria, our investigation replaces the trust's own local investigation.

Our investigations identify the contributory factors that may have led to harm or had the potential to cause harm to mothers / birthing people or babies. The safety recommendations we make aim to improve healthcare systems and processes, as well as reducing risk and improving safety. We work closely with women / birthing people, their families and healthcare staff who are affected by patient safety events and do not attribute blame or liability.

We share our investigation report with the family and trust affected, and the trust is responsible for carrying out any safety recommendations made in the report. In addition, we identify and examine recurring themes that arise from trust-level investigations so that we can make safety recommendations to local and national organisations for system-level improvements in maternity services.

On 1 October 2023, the MNSI programme moved from the Healthcare Safety Investigation Branch (HSIB) to be hosted by the Care Quality Commission (CQC). The functions of the programme remain the same.

About this report

This report provides an overview of work of the Maternity and Newborn Safety Investigation programme during 2023/24. It highlights activities carried out since 1 October 2023 and our plans for 2024/25. Its aim is to provide healthcare organisations, policymakers and the public with insights into our work.

Foreword

Sandy Lewis
Director Maternity and
Newborn Safety Investigations

MNSI transitioned to be hosted by the Care Quality Commission (CQC) on 1 October 2023. This change followed five years of developing our investigation programme within the Healthcare Safety Investigation Branch (HSIB). The value of our independent safety investigations is firmly established within trusts and is recognised as crucial for families and those we work with.

Our investigation programme has undergone significant development since its inception in 2018; the more we learn, the more work and development we need to undertake. We receive referrals from trusts regarding events which relate to mothers, birthing people, babies and their families on a daily basis. Each family we speak to shares their experience with our team and we aim to provide them with answers to their questions though our investigation process. We repeatedly hear their hope that no other family goes through what they have experienced, but acknowledge this remains an ambition within maternity care in England which is yet to be achieved. Taking the action required to ensure that everyone receives safe, personalised maternity care must therefore be prioritised and sustained. We are committed to playing our part in the system-wide change which is needed to turn this ambition into reality.

Our highest priority is to continue to develop a more detailed understanding of the factors that support and promote health equity, and how these should optimise the outcomes for women / birthing people and their babies. The question is why do women / birthing people and babies not receive the individualised care that optimises their outcome? We have only touched the surface of the reasons behind these factors; the innovative work we are developing will help us to understand this further over the next year.

Another priority area is further understanding the information we gather as part of our investigations so that we can inform and support learning within perinatal services in England. Whilst we investigate events that may be uncommon in an individual trust, our approach to wider learning is providing significant opportunities to influence system change in all trusts.

Our programme provides the opportunity to reflect on multiple aspects of the healthcare of women / birthing people and children, such as considering the impact of childbirth on long-term health or exploring the system factors which contribute to preterm birth. They also give us the chance to better understand the systems and processes that enable many women / birthing people and babies to have a positive experience of pregnancy, labour, birth and the postnatal period.

Our work could not be achieved without the commitment of every member of the MNSI team, including those who understand safety investigations and provide essential advice and the clinicians who continue to practice alongside their MNSI role.

Our investigations are also supported by those working in patient safety teams at trusts, as well as staff involved in providing care to mothers / birthing people and babies throughout pregnancy and in all clinical settings. The openness and willingness to improve remains a strong theme of our work with clinicians.

We remain in the privileged position of working alongside families who have experienced harm during maternity care. Without their willingness to participate and share their experiences, our investigations would be diminished.

Introduction

The maternity investigation programme is part of the national strategy to improve maternity safety across the NHS. The programme began under HSIB in April 2018 and was embedded in all trusts providing maternity care in England within 12 months. Currently, our teams work with all 121 trusts which provide maternity care in England.

During 2023/24, we received 945 referrals, of which 795 met our criteria and 150 did not. Of the 795 which met our criteria, 591 progressed to investigation and 204 did not. This was because:

- they did not meet the MNSI criteria;
- the family did not agree to the sharing of medical records, which is essential for an investigation to proceed; or
- for potential severe brain injury referrals, there was no severe brain injury and no trust or family concerns.

Our investigation teams are made up of individuals with diverse experience. They work closely with clinical advisors who are still actively practising in frontline healthcare roles. They also consult with relevant advisors from across the United Kingdom to help strengthen our understanding of events. In addition, the programme's key functions are supported by our business services team, who ensure all reporting requirements are met.

Our achievements

6,018 REFERRALS

Since its launch in April 2018, the programme has received 6,018 referrals and progressed 3,856 investigations. At the end of March 2024, we had completed 3,505 maternity investigations in England.

86% OF FAMILIES

Meaningful engagement with, and involvement of women / birthing people and families, remains high with 86% of families engaged with our investigations. This engagement starts with our teams making initial contact. With the family's agreement, we will request more detailed involvement throughout the duration of an investigation.

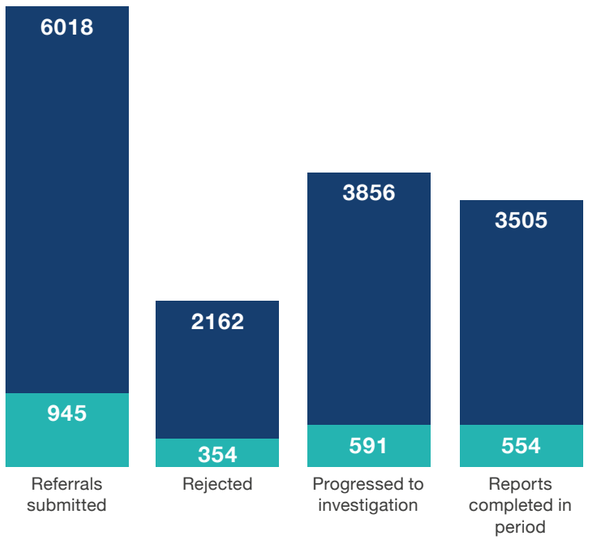
IMPROVED INCLUSIVITY

We have developed a new investigation report template and changed our investigation processes to improve inclusivity. This change will also increase the potential for learning and addressing how inequalities and ethnicity impact care.

Operational performance in 23/24

Maternity referrals: Summary

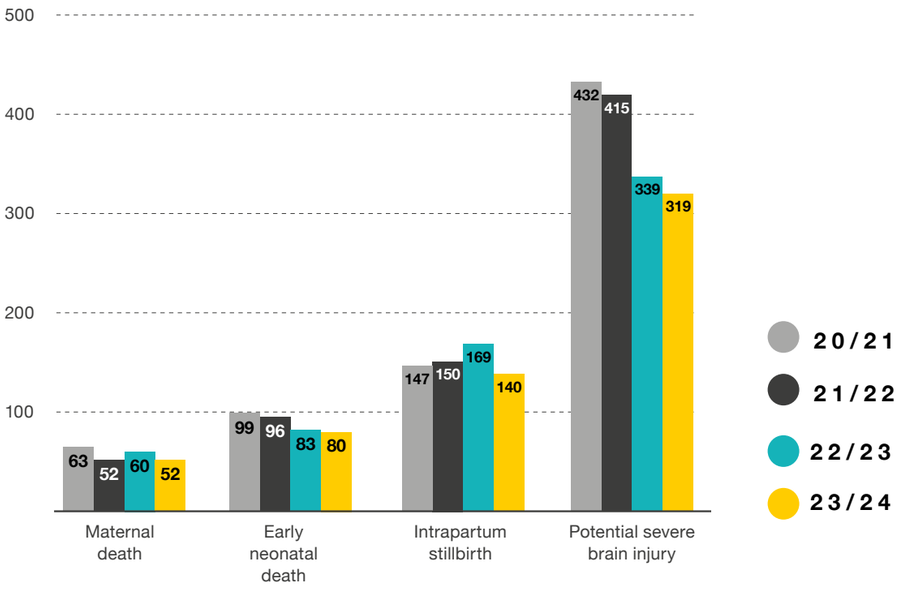
1st April 2018 - 31st March 2024



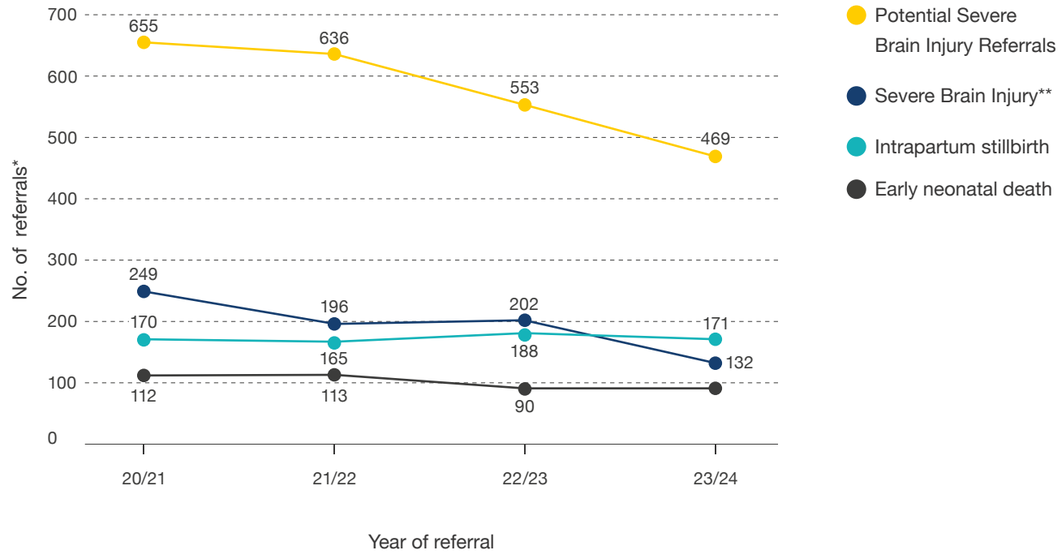
PROGRAMME TO DATE
1st April 2018 - 31st March 2024

YEAR TO DATE
1st April 2023 - 31st March 2024

Referrals which progressed to investigation by criteria and year



Referrals* for potential severe brain injury, intrapartum stillbirth and early neonatal death



*Referrals that met standard criteria (active, completed, rejected Lack of family consent (LOFC) and rejected no severe brain injury or trust/family concerns).

** As defined in the MNSI directions.

Note: 2020/21 was the first full year of data where actual severe brain injury was recorded separately.

Outcomes and impacts: Emerging themes from MNSI investigations completed during 2023/24

We have identified the following five themes from the safety recommendations made to trusts during 2023/24, which are similar to those found in previous years:

- Clinical assessment
- Fetal monitoring
- Escalation
- Clinical oversight
- Risk assessment

In total, we made 1012 recommendations in 2023/24.

Highlights of the last six months

British Intrapartum Care Society annual conference

In November 2023, we ran two workshops at the British Intrapartum Care Society (BICS) annual conference. These focussed on family involvement and risk assessment.

Family involvement

The first workshop centred around how to ensure family involvement during patient safety investigations. It explored why family engagement is necessary, what foundations need to be in place to enable family involvement and what models of best practice organisations can consider.

Risk assessment

The second workshop explored the language used in risk assessment. It came after we published a national learning report, called 'Assessment of Risk During the Maternity Pathway', in March 2023.

The workshop asked a key question: "Does the language used in risk assessment and screening documents avoid binary definitions of risk, and instead promote dynamic and holistic risk assessments supporting a multi-professional approach?"

The conversation focussed on what is meant by risk (especially low risk and high risk), and what we mean by obstetric or midwife-led care. The workshop prompted useful discussions and food for thought. Participants talked about how it takes a multi-professional team with the woman / birthing person, family and baby at the centre to manage antenatal, intrapartum and post-natal care. They also suggested that perhaps it was time that the terms 'midwife-led', 'obstetric-led', 'low risk' and 'high risk' were confined to the history books.

Local rationality questions for healthcare investigations

During the year, MNSI investigator Louise Roe developed a tool to support the way we approach staff following a patient safety event. This came after she found that at times, the quality and depth of the information we obtained did not fully answer all the 'whys' around decision-making at the time of the incident.

Whilst the impact of a patient safety event is often devastating for patients and families, the emotional effects on staff involved are also well documented (Wu and Steckelberg, 2012). It is therefore important to ask questions that explore

local rationality and let us really understand why a decision, action or inaction made sense at the time without making staff feel interrogated or blamed.

Whilst the focus of an investigation should be on systems, processes and human factors, we know that healthcare staff will often blame themselves when a patient safety event occurs. Our role as the investigator is to ensure that we do not exacerbate this further in the way we ask questions, especially as this can often stay with staff long after our discussion with them has finished. However, by asking the right questions, we have the ability to take the focus away from the individual and show them that our real interest lies in the information that was available at the time, influencing human factors and the systems, processes and situation they were working within.

Given the breadth of possible lines of questioning, it is important for the investigator to choose questions that draw out meaningful and relevant responses and provide what we want to know. The tool developed by Louise supports investigators to ask the right questions, in turn ensuring findings are more accurate and can therefore help us to make the right recommendations for change.

We published a blog and ran two webinars to launch the tool to healthcare organisations and other investigation industries.

Community public access defibrillators

Our work in relation to community public access defibrillators (CPADs) started when the programme was part of the Healthcare Safety Investigation Branch (HSIB) and has continued following the transition to MNSI.

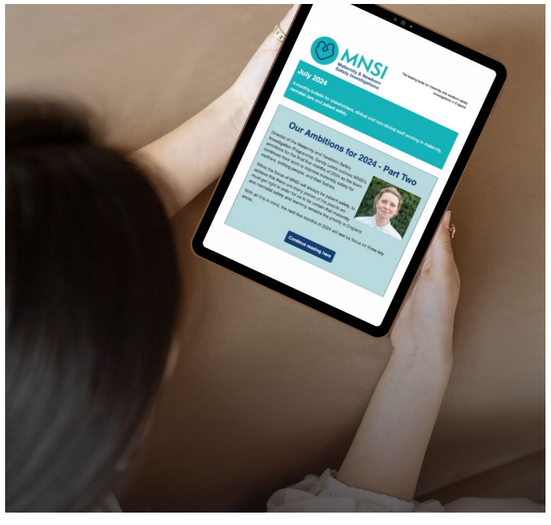
CPADs contain an automated electronic device (AED) that, in the event of a sudden out-of-hospital cardiac arrest, can provide life-saving treatment by delivering an electric shock to the heart. CPADs can be found in public areas such as disused telephone boxes or community centres. Often the defibrillators are locked, and a special code is needed to open the unit.

We became interested in the CPADs following instances where access to them was impacted by their location, or when an individual defibrillator was not registered on a centralised database called ‘The Circuit’. MNSI learned there are variations in whether defibrillators are stored in locked or unlocked cabinets, and whether they were positioned in an accessible location.

In England there are approximately 82,000 CPADs (January 2024). Most of them can be accessed by the public following an out-of-hospital cardiac arrest. However, if a CPAD has been accessed and the AED used, then it shows as unavailable on the system. In some instances, CPADs are also registered to schools or businesses and, as a result, are not accessible for out-of-hours use.

Our research has taken place in collaboration with the British Heart Foundation, UK Resuscitation Council, St John Ambulance, Association of Ambulance Chief Executives and NHS England. The learning from the MNSI investigation which referenced CPADs was also shared as part of a national meeting organised by the British Heart Foundation.

External bulletin



Following the launch of MNSI in October, we now publish a bi-monthly bulletin for stakeholders and both clinical and non-clinical staff working in maternity care and patient safety. Click here to register to receive this bulletin.

Collaborative work

MNSI is committed to collaborating with external stakeholders to share data and enhance patient safety. This year, we have worked closely with MBRRACE-UK and contributed to chapters in its annual report focussing on maternal deaths and deaths from venous thromboembolism. The report will be published later in 2024.

Factors affecting the delivery of safe care in midwifery units

In May 2024, MNSI published a national learning report called ‘Factors Affecting the Delivery of Safe Care in Midwifery Units’. It highlights key learning and prompts to help trusts to consider how safety risks can be mitigated to drive further improvements in care. The report was based on an analysis of 92 investigations completed on or before 14 June 2022 and identified four common themes as issues impacting on maternity safety:

Work demands and capacity to respond – the number of tasks needed to be done and whether there are enough, suitable staff, and appropriate physical space, to do them. When work demands exceed capacity, staff must make a trade-off between efficiency and thoroughness. Mismatches between demand and capacity often resulted in delays in care and / or tasks during a mother / birthing person's labour. Safe care in midwifery units is also affected by capacity issues in other areas, such as obstetrics and ambulance trusts.

Intermittent auscultation (IA) – a method used to assess a baby's heart rate as an indicator of their wellbeing. IA was not carried out in line with guidance in almost half (49%) of the maternity investigations we analysed. This was often associated with a high workload. Evidence from the reports, together with published literature, suggests that carrying out IA in line with guidance is difficult to achieve in practice. Research is underway to understand the reasons for this and to develop a toolkit to improve the way IA is done.

IA is a complex task that relies on sustained attention, often over a 12-hour shift. However, the environment in which IA is carried out is often not conducive to the task and mental effort required. For example, there may be physical constraints and noise at a level which impairs clinical performance.

How prepared an organisation is for predictable safety-critical scenarios, and the role played by in situ simulation (a training method that involves staff rehearsing scenarios in the workplace). There was limited evidence of prospective risk assessment to identify and address weaknesses in the systems and processes relied on in scenarios such as transfer. Self-assessment against the Midwifery Unit Standards provides a framework to support prospective risk assessment. In situ simulation to rehearse safety-critical scenarios is useful, particularly when it includes staff from other areas.

Telephone triage – the assessment a midwife carries out when a pregnant woman / birthing person telephones because they have gone into labour or have a concern about their pregnancy. There is variation in the advice and information given during telephone triage and in the recording of information about calls, as well as a higher risk of information being lost if there are conversations in different geographical locations. Readily available and easily accessible clinical information supports effective telephone triage and decision-making. However, using different digital information systems and mix of handwritten notes and electronic systems hinders staff in effectively triaging pregnant women/birthing people. Giving pregnant women / birthing people multiple telephone numbers for different obstetric and midwifery units to ring for advice can also create confusion and increase the risk of information being lost.

Despite the importance of telephone triage, there is no national guidance to standardise the process and ensure that pregnant women / birthing people are given consistent assessment and advice.

Family / staff video

We are grateful to have been able to work with one family to develop a family information video. This video will be shared with other families who may be approached by MNSI in the future to help them understand what to expect from an investigation and how they can be involved.

As part of an MNSI investigation, maternity investigators will interview trust staff or other individuals to collate information which may help to inform the overall investigation report. We recognise that this can often cause anxiety for trust staff, so have developed a staff information video to help support those who are being interviewed.

Within the video, maternity investigators outline the process of an investigation and what to expect if you are being interviewed. Trust staff also share their own experiences, offering reassurance to colleagues that the process does not need to be stressful and can often be a positive experience.

Our thanks go to everyone who gave up their time to contribute to the video and support others who will be helping with our investigations in the future.

Trust and family feedback

Every family (100%) who provided feedback about the MNSI programme between 1 October 2023 and 31 March 2024 either strongly agreed or agreed that they had been suitably engaged throughout the investigation, and were satisfied with both the investigation and the report.

Some of the comments received from families, together with an outline of their stories, are summarised over the next three pages.

Early neonatal death

A 23-year-old white British mother in her first pregnancy booked for maternity care at nine weeks and six days' gestation (9+6). She followed a midwifery-led care antenatal pathway.

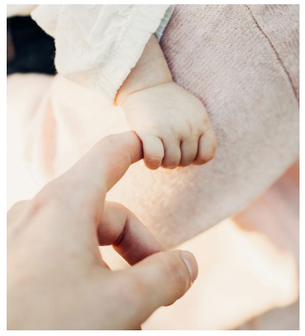
The mother's labour started naturally at 41+1 weeks. However, there were concerns about the baby's heart rate. The baby was born via an assisted vaginal birth but needed resuscitation following the birth and was transferred to a special care unit.

The baby's condition did not improve and following discussion with the parents, the baby was placed on a comfort care pathway. The baby died at seven hours and seven minutes old.

The MNSI investigation made six safety recommendations.

The baby's parents said:

> The findings from the investigation have been most helpful to us. Even though it has been hard to find out the circumstances surrounding our baby's death, it has been extremely helpful to know exactly what happened.
>
> We would like to thank our investigator for everything they have done for us. They supported us through the worst time of our lives and made us feel cared for. We definitely feel our voices have been heard and reflected properly in the report.
>
> We wish our precious baby had not died and that we didn't need to use this service, but are so glad it exists. It is so important that families can find out exactly what happened to their baby without having to try and do it themselves.
>
> We feel that our investigator went above and beyond what we expected from them, and will never forget what they have done for us and how kind they were to us in such a dark time of our lives.



Maternal death

A 35-year-old white British mother was booked for obstetric-led care at nine weeks and six days' gestation in her fifth pregnancy. She followed a high-risk antenatal pathway because of factors identified at her booking.

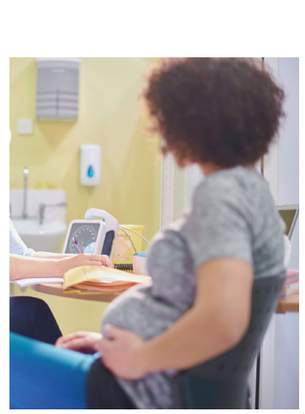
The mother gave birth to a healthy baby at 40 weeks and three days without the need for any assistance or intervention. Shortly afterwards, the mother felt unwell and fainted. It was initially thought she might be dehydrated, and she was given intravenous fluids. However, her condition worsened and she started experiencing chest pain and shortness of breath. The healthcare team suspected she had a blood clot in her lung and began treatment.

The mother's heart then stopped. She was resuscitated and her heart started beating again 45 minutes later. She was taken for emergency surgery to remove a ruptured spleen and cared for in the intensive care department, but died after her heart stopped for a second time.

The MNSI investigation made seven safety recommendations.

The mother's family said:

> I would like to thank the investigators for showing our family such support, honesty and kindness, and for making what has been a never-ending nightmare of pain a little more bearable.



Intrapartum stillbirth

A 25-year-old white British mother in her first pregnancy was booked for high-risk, obstetric-led care at seven weeks and three days' gestation. She had an unremarkable antenatal period and care was provided in line with her identified needs and national guidance.

At 40+3 weeks, the mother went to a maternity day assessment unit in suspected early labour. The baby's wellbeing was assessed using a cardiotocograph and was initially found by staff to be abnormal before later normalising. A plan for inducing labour was discussed but later discounted. The mother was discharged the following day and advised to contact her midwife for continued follow-up.

The mother was not able to arrange to see her named midwife and was instead given an appointment with another midwife at 41+5 weeks. The day before the appointment she returned to the maternity day assessment unit reporting reduced baby movements. The mother was assessed and staff could not hear the baby's heartbeat. The baby's death was confirmed following an ultrasound scan. The mother's labour was induced and the baby was born at 41+6 weeks. Placental cells were examined under a microscope and showed signs of infection and reduced placental function.

The MNSI investigation made one safety recommendation.

The mother said:

> I reached out to MNSI about my case as it was not passed on by the trust. Since then, the MNSI team has been phenomenal in dealing with our investigation and us. They have really put in so much hard work considering the investigation happened a year later, and have really done our baby justice. They have always made sure my partner and I were involved in every step. We really appreciated that, especially my partner as the father is often forgotten.
>
> The MNSI team are amazing, and were so sensitive and patient with us. It was really nice getting to know both of our MNSI investigators through this awful time. We really appreciate all the hard work that went into our report from MNSI and the people in the trust who were willing to help. It is always hard to re-read the report and as advised by our investigator, we took time and looked after each other through our reading. The MNSI were quick and efficient in ensuring we got answers.

Communication

Communication is a key patient safety issue in maternity care, as well as a significant determinant in the experience of families. MNSI recognises that this is a challenging area for healthcare providers and that a significant amount of work is being carried out nationally to improve communication between maternity teams, women/birthing people and families (Cull J, Anwar N, Brooks E et al. MIDIRS Midwifery Digest, 2022).

During the year, we published a blog which highlighted the safety factors surrounding effective communication. The article also identified factors that work well, explored some of the barriers to effective communication and acknowledged the work that is taking place to overcome them.

The blog reflected on a review of investigation data from March 2022 to March 2023. This found that in almost a third (31%) of investigations, additional support was needed to facilitate our work with families. In 57% of those cases, this related to communications support, and predominantly focussed on the use of interpretation and translation services so that families could share fully with us their experience of the care that they and their babies had received.

Safety systems factors that worked well: Examples from maternity investigations

- Timely assessment of women's needs and communication of those identified support needs to the maternity multidisciplinary team. This led to women being able to access all relevant services during the pregnancy and being fully involved in decision-making.
- Verbal interpretation services provided consistently in the antenatal period because it was well known and documented that communication support was required.
- Interpretation services that were available 24 hours a day, were easily accessible and straight-forward for maternity teams to use.
- Technological equipment being available to provide bedside interpretation for women.

Safety systems factors where there were barriers to effective communication: Examples from maternity investigations

A number of maternity investigations have identified gaps that can arise in communication. Most commonly, these relate to language barriers in written, oral and online communications:

- No assessment of potential communication support needs carried out, leading to no support being provided through the pregnancy.
- Women / birthing people feeling that they do not need an interpreter as they speak some English. This can lead to a potential gap in understanding of information given and an inability to make fully informed choices.
- Interpretation services requested but not able to be provided (examples include difficulty in accessing interpretation services when an attendance is unplanned or an emergency, being unable to access interpretation in a woman / birthing person's first language, delays in connecting to telephone interpreter or the quality of interpretation).
- Family members being asked to interpret or women / birthing people choosing to having family members interpret for them.
- Staff members interpreting, sometimes in a shared language but not a woman's/ birthing person's first language.
- Lack of written information available in a woman's / birthing person's first language.

Other barriers to effective communication have been identified in some investigations, for example:

- Technological barriers (access to and effectiveness of apps, digital exclusion).
- Barriers to engaging with healthcare services (for instance, a lack of clear information on telephone numbers to call for information, test results or advice).
- Technical language barriers (the use of medical language and 'jargon' in oral and written communications).
- Training barriers (there is no national provision of advanced communication skills training for maternity teams in identifying communication support needs).
- Barriers regarding the absence of effective tools. There are no nationally agreed tools consistently established for use in assisting maternity teams in assessing women's / birthing people's communication needs.

MNSI recognises the healthcare system's commitment to improving the communication support available to women/birthing people and maternity teams, and the work that is currently being undertaken. Moving forward, we intend to carry out further work on the theme of communication by engaging with women/ birthing people, families and stakeholders to further improve the safety and experience for women / birthing people throughout their pregnancy journey.

Inspiring inclusion

In a world where diversity and inclusion are paramount, the journey towards a more equitable society begins with education and awareness. As the theme for this year's International Women's Day (8 March) was 'inspire inclusion', we have reflected on the steps we are taking to inspire inclusivity within our investigative practices. Central to this has been a tailored training programme delivered by Birthrights, a UK charity dedicated to protecting human rights in pregnancy and childbirth, which our team has completed to help us further embrace inclusivity in our work.

The training sessions were designed to empower the MNSI team to understand human rights and systemic racism in maternity care. By focussing on the experiences of ethnic minority women / birthing people and families, the programme aimed to instil a deeper appreciation for the lived realities of individuals who may face unique challenges within the healthcare system.

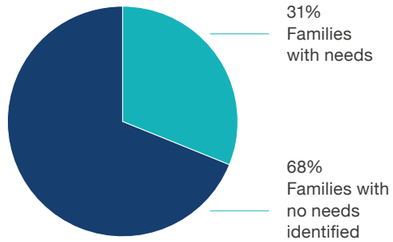
Celebrating International Women's Day also gave our team the opportunity to recognise the intersectionality of gender, ethnicity and healthcare outcomes. MNSI's dedication to examining systemic issues such as racism in maternity care aligns with our commitment to improving outcomes for all women and babies, regardless of ethnicity or heritage. This imperative arises from statistics which show that black women in the UK have a mortality rate almost four times higher than that of white women. Black and minority ethnic women also continue to experience higher rates of maternal and neonatal mortality, which is often attributed to complex social, economic and healthcare system factors as well as systemic racism.

Addressing this disparity necessitates strategies that address structural inequalities, improve access to quality care and prioritise culturally competent approaches within maternity services. By advocating for systemic changes and emphasising the importance of culturally sensitive care, MNSI is playing a crucial role in advancing equity and improving maternal health outcomes for all women and birthing people in England.

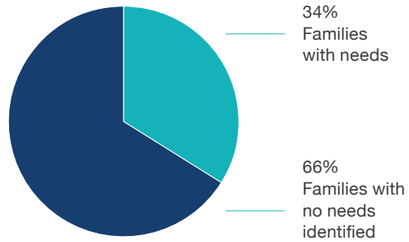
The journey towards inclusion is not a destination but a continuous process of learning, unlearning and growth. Through initiatives like the training programme delivered by Birthrights, organisations such as MNSI are taking proactive steps to inspire inclusion, foster diversity and champion human rights in every aspect of their work. As we celebrate these efforts, it is important to remember that true progress lies in our collective commitment to creating a world where everyone is seen, heard and valued.

The Family Inclusivity Toolkit – reflecting on two years of data

Over the past two years, we have used our Family Inclusivity toolkit (FIT) to gather information and data that helps us make sure we are inclusive in how we work with families during investigations. Since the toolkit was introduced, around a third of the families we meet have shared one or more needs with us to help inform how we can work together more effectively and adjust our processes wherever necessary.



YEAR ONE



YEAR TWO

Consistently the highest need (53%) families tell us about is an adaption to the way we communicate. This may involve the need for language services, help understanding documents or requiring printed documents or information when families have no access to technology.

The next impact shared with us is that of the health and wellbeing. In 36% of cases, considerations included areas such as mental health, which could be either pre-existing or had been caused by the patient safety event.

The final area of need identified to us (11%) highlighted what is important to families within their community setting. This can include their living situation, considerations around their or their wider family's safety or the way they choose to live.

Asking what is important to families at the beginning of our conversations helps us to understand the best way we can work together and ensures that we do not intentionally or unintentionally prevent them from making a choice about how they wish to be involved.

Over the coming year, we plan to take this inclusivity approach to the next level by looking at how not responding to such needs creates health inequalities.

Developing our investigation processes and reports

Before the transition to being hosted by the CQC in October, we worked closely with the HSIB to further develop our investigation process and created a new investigation report template. From 1 April 2024, all new referrals have used these resources. This important development was shared with our stakeholders in a blog.

We trialled several changes to our investigation approach and report style before introducing the new resources. We tested the new report template during seven pilot investigations and used the internal and external feedback we received to further develop and refine the content. We also used several respected national publications to shape the investigation report template and processes, including:

- the Chartered Institute of Human Factors and Ergonomics white paper, 'Learning from Adverse Events' (CIHFE, 2020);
- the 'Patient Safety Incident Response Framework' (PSIRF) (NHS England, 2022);
- The Learn Together Investigation Guide; and
- NHS England's guidance on supporting patient and family involvement in patient safety investigations.

The new maternity report template builds on our focus on improving inclusivity and further invites the involvement of patients and their families in the investigation process. It also gives families the opportunity to personalise the report by including a short paragraph about themselves or their baby.

This is an example of how that paragraph may be written.

About baby Ria
Ria is Shahina and Kaustav's third child. Everyone has enjoyed getting to know him and his family are particularly happy that he is now home. Ria's big sister, who is seven-years-old, is particularly keen to help with changing and feeding duties. Shahina and Kaustav hope this report makes a difference to other families birthing their babies at the trust.

MNSI recognises that in a complex system such as healthcare, it is rarely possible to identify the exact cause of an outcome. Instead, it is more helpful for safety investigations to consider the multiple contributory factors to what happened and changes to the work system that could reduce the chance of a similar event occurring. Maternity investigators have been able to use different methods to help understand the factors that contributed to an unexpected or unwanted outcome for a mother/birthing person and / or baby. This includes an appreciation of how staff and organisations interpret national and local guidance, understand why decisions made sense at the time and how staff adapt to uncertain and ever-changing situations. Our maternity investigators speak to families and staff using the local rationalisation interview tool developed by Louise Roe, and may also visit trusts to observe the clinical environment, hold a focus group or complete a 'walk through, talk through' to see work as it is being done.

Investigators can use their knowledge of the system-wide factors to inform meaningful learning through the reports, with safety recommendations and the addition of safety prompts. A change to our safety recommendations definition provides MNSI with a greater opportunity to share the learning from our investigations for the benefit of families, trusts and national bodies to inform safe maternity care. The new MNSI report template also allows the investigation team to make safety recommendations whenever there is evidence that something needs to change to make care safer – whether or not it 'caused' the event being investigated.

MNSI definitions of recommendations and safety prompts

Findings, safety recommendations and safety prompts

This report contains findings from our analysis of the evidence gathered during our investigation. The report may also contain safety recommendations and safety prompts.

Safety recommendations are made to an NHS organisation when the evidence indicates a change is needed to make care safer.

Safety prompts describe an action that may help to improve safety at a local level and where there was insufficient evidence to support a safety recommendation. This could be due to insufficient evidence from interviews, or because the issue fell outside the direct scope of the investigation.

Not all reports will contain safety recommendations or safety prompts. On these occasions, maternity services are encouraged to use the findings within the report to promote and support learning.

An example MNSI safety prompt:

The investigation found the time on the theatre clocks and equipment in the operating theatre differ.

1. Are there any barriers to ensuring the times are synchronised?
2. Is there a checklist at the start of each procedure to acknowledge any discrepancies within the clocks with an operating theatre?

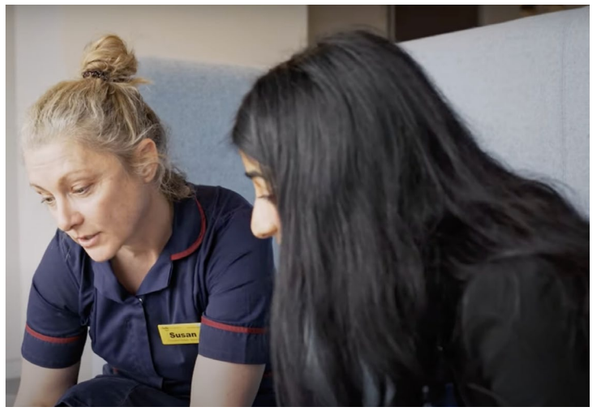
A comprehensive face-to-face and online training programme took place during February and March to prepare for the introduction of the new template from 1 April. More than 95% of our staff received training and ongoing training and support is being provided by the investigation development group. Trusts and families are beginning to receive investigations using the new report template. A full evaluation of the new process and template will take place in the autumn as part of our internal quality improvement programme.

Competency framework

In January 2024, we piloted a competency framework and associated portfolio for maternity investigators. This identified 24 competencies which give individuals a description of what skills, knowledge and behaviours are required within their role. The competences also provide line managers with a clear description of what is required when managing and setting objectives for staff, as well as help to identify resourcing, training and development needs.

Supporting our staff

We have set up a psychological screening programme to support our team, who repeatedly discuss distressing incidents as part of their day-to-day activities. This protective initiative enables us to educate and support staff and monitor the trauma impact of the work they conduct.



Areas of focus for 2024/25

Thematic learning

MNSI holds a significant amount of information and is in a privileged position to access more detailed information to fully understand the 'whys' behind safety events. Over the next year, we want to build on the work we have already carried out in this area and challenge the possibilities of how this can inform the safety landscape within maternity care. This presents opportunities for collaboration to strengthen our emerging thoughts and support perinatal services to inform and prioritise the improvements they are making.

Equity, Diversity & Inclusion (EDI) - Health Equity Assessment and Resource Toolkit (HEART) / Health Equity Warning Score (HEWS)

Equality, diversity and health equity data consistently demonstrates that women/ birthing people from a non-white background have poorer outcomes than those from a white background. MNSI wants to build on the intelligence we have already gathered and understand why these outcomes occur, while exploring what prevents the care women receive from being aligned to their individual needs and those of their families.

This year, we have developed the Health Equity Assessment and Resource Toolkit (HEART) to improve the recognition and analysis of health inequalities within our maternity investigations.

Due for roll out in November 2024, HEART will ensure health equity factors are systematically considered in every investigation. The toolkit will help MNSI investigators by providing:

- a topic summary
- triggers to recognise health inequalities
- a question bank for family meetings
- a glossary of key terms
- a comprehensive evidence repository and
- links to previous MNSI reports and safety recommendations.

HEART is an interactive PDF which includes calculation of a Health Equity Warning Score (HEWS), which is a way of stratifying a woman's / birthing person's individual risk of experiencing barriers to health equity. This score is recorded in our investigation management system and reviewed by our clinical advisory panels to explore how health equity factors will form a key line of enquiry in the investigation.

In the long term, using HEART and HEWS will help us collect detailed data on health inequalities and identify themes to feedback into the wider system. Over time, it will enable us to retrieve meaningful data to analyse trends and identify common health equity challenges. This data is crucial for developing targeted interventions and sharing insights both locally and nationally.

The implementation of HEART and HEWS puts health equity at the forefront of our maternity investigations and will help us improve equitable care for all mothers/birthing people and babies while contributing to broader health equity initiatives.

Conclusion and looking ahead

Over the coming 12 months, we want to explore opportunities to further expand our work. This could include looking in more detail at aspects of maternity safety which may be touched on during safety investigations but are not fully explored as they remain outside of the current scope of MNSI work. This emphasises the need for the health of women/birthing people to be a priority in the overall healthcare agenda.

The programme has demonstrated it is able to provide consistently high-quality safety investigations, having completed over 3500 investigations related to maternity care in England.

The next year for MNSI brings a number of opportunities and an ability to focus our work on areas we have touched on but not been able to fully explore.

We have set three ambitions over the coming year, aligning with our values and bringing back into focus where we can inform safe care within maternity services.

There have been many reports highlighting the health inequalities across maternity services, our work provides the ability to understand why this is occurring, exploring how this is impacting on families when this has become their lived experience. The development of the HEART / HEWS work is our opportunity to start understanding the challenges and informing where these essential changes need to be made.

Development and improved processes within our safety investigations is demonstrating the increasing maturity of the programme, this is alongside a team who always want to improve and explore approaches in our work. We have a dedicated and experienced team whose safety investigations experience and capability is able to have a wide reaching impact for families and trusts alongside the wider system. Over the next year we want to explore these possibilities within our work, in collaboration with others and ensure maternity safety remains a continued priority.

We are in the privileged position to have an understanding of the themes arising from safety investigations across maternity services and we are developing how we share this information in an approach which ensures that it informs those providing frontline care alongside those who commission and have the strategic oversight of the services. We know the development of this area of our work will only continue to grow and become more informative.

In addition to our own work, there are a number of reviews taking place in maternity care across England. These reviews will provide a unique insight into maternity care at locations across England. We will use the evidence; insight and any recommendations made within these reviews to inform our own practice and ensure that our investigation process remains up to date and relevant to maternity care in England.

Improving the safety of maternity care for all women / birthing people, their babies and their families remains our highest priority and it is with this mission in mind that we look ahead to the remainder of 2024/25.

MNSI
Maternity & Newborn Safety Investigations

Further information

More information about MNSI – including its team, investigations and history – is available at www.mnsi.org.uk

If you would like to request an investigation then please read our guidance before contacting us.

To keep in touch you can subscribe to our bi-monthly bulletin or follow us on LinkedIn where we raise awareness of our work and to share our publications, news and events.

Contact us

If you would like a response to a query or concern please contact us via email using enquiries@mnsi.org.uk

We monitor this inbox during normal office hours - Monday to Friday from 09:00 hours to 17:00 hours. We aim to respond to enquiries within five working days.

To access this document in a different format – including braille, large-print or easy-read – please contact enquiries@mnsi.org.uk

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www.mnsi.org.uk
@maternityandnewbornsafetyinvestigations