

Maternity and Newborn Safety Investigations (MNSI) programme

Annual Report 2025/26

Building a safer future through
partnership and prevention



MNSI
Maternity & Newborn
Safety Investigations

A stylized graphic in the background consisting of two overlapping human-like shapes. Each shape has a circular head and a body with arms extended outwards. The two shapes are positioned such that their arms reach towards each other, forming a heart-like silhouette in the center. The entire graphic is rendered in a light blue/teal color against a dark blue gradient background.

**Building a safer future
through partnership and prevention**

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About MNSI

The Maternity and Newborn Safety Investigations (MNSI) programme conducts independent investigations into safety events involving NHS-funded maternity and newborn care in England that meet its [published referral criteria](#). Referrals are made by the NHS trust responsible for the care, recognising that patient harm is most often linked to system and process issues rather than individual actions.

MNSI investigations explore factors that may have contributed to harm, or the risk of harm, to women and babies. The programme's findings, safety prompts and recommendations focus on strengthening healthcare systems and processes to improve the quality of care and enhance safety. Throughout the investigation process, MNSI engages with affected women, families and healthcare staff. MNSI does not blame or state liability. A safety investigation report is shared with both the family involved and the trust providing care. The trust is responsible for implementing the learning from the report and undertaking the safety recommendations. MNSI also analyses patterns and identifies themes across investigations to develop and share learning in a variety of approaches. These support improvements at local, regional and national levels across maternity and newborn services.

Since MNSI was launched in 2018, more than 4,700 independent investigations into maternity and newborn safety events have taken place. In March 2026, the Department of Health and Social Care confirmed that the MNSI programme will continue until at least 2030, enabling investigation work to go further in improving the safety of maternity and newborn care across England.

About this report

This report provides an overview of the work of the MNSI programme during 2025/26. It highlights activities carried out since 1 April 2025 and outlines MNSI's plans for 2026/27. Its aim is to provide healthcare organisations, policymakers and the public with insights into the work of MNSI. Throughout this report, MNSI uses the word mother to describe women and people who use maternity and newborn services. MNSI acknowledges that not all pregnant or birthing people identify as women or mothers. This position reflects the Supreme Court ruling in April 2025 that the legal definition of a woman is based on biological sex.

Foreword



Any loss or harm of a baby or woman has a devastating and lasting impact on families, leaving them facing profound grief and questions about what happened and why. The work of the Maternity and Newborn Safety Investigations (MNSI) programme helps families receive the explanations they deserve and in supporting the wider system to learn from what has happened – so we can better understand what changes are needed so services can become safer, more compassionate and more responsive for women, babies and families.

We are at a critical moment in maternity and neonatal care, following the findings and recommendations of the Independent National Maternity and Neonatal Investigation led by Baroness Amos. The investigation highlighted that too many women and families are not being listened to, that accountability is not always delivered when things go wrong, and that racism and discrimination continue to drive unacceptable inequalities in outcomes. It described a system that is fragmented, overly complex and too slow to learn and underlined the importance of independent, compassionate and effective investigations for families seeking answers.

We know that there is more to do in tackling an overly complex system of investigations and reviews so that they support families and lead to meaningful change. We have heard first hand from families that failures to support them when things go wrong compounds their harm. Which is why, together, across the sector, we must continue to and always put families first.

As the Minister for Women's Health and Maternity, I am privileged to be responsible for maternity and neonatal care in England, including the MNSI programme.

I would like to thank everyone involved in preparing this report, and all those working to undertake MNSI investigations. This work matters deeply: to the families who deserve answers, to the staff and services seeking to improve, and to our shared ambition to make maternity and neonatal care safer, fairer and more compassionate for every family.

Baroness Gillian Merron

Introduction

The Maternity and Newborn Safety Investigations (MNSI) programme is a key part of the national strategy to improve safety and outcomes in NHS maternity and newborn care in England. Guided by values of collaboration, integrity, excellence and learning, we support system-wide improvement and safer care for families.

All NHS trusts are required to notify MNSI of specific patient safety events, enabling independent, high-quality investigations and the development of evidence-based safety recommendations to drive improvement, locally and nationally.

MNSI works with families, trusts and staff, applying a transparent, systems-based and learning-focused approach. Investigations do not seek to blame but focus on identifying opportunities to strengthen care systems and prevent future harm.

Multi-disciplinary investigation teams, supported by experienced clinical advisers and subject matter advisors, ensure robust analysis and high-quality insight. This work is underpinned by the MNSI business services team, which provides essential governance, assurance and operational support to maintain consistency and excellence.

Established in 2018 within the Healthcare Safety Investigation Branch, MNSI is now hosted by the Care Quality Commission (CQC).

Reflections on the past year



Sandy Lewis
MNSI Programme Director

“Over the last year, the MNSI programme has continued to evolve and develop the work we undertake with families, trusts and staff providing clinical care. The opportunities to share our work and collaborate has enabled us to work with inspirational families, clinical teams and stakeholders with the collective ambition to see a demonstrable impact on perinatal safety. I would like to sincerely thank families for trusting in us to share your experiences, trusts for working with us to implement learning, and staff for your openness to meaningfully implement safe care.

“The publication of our two-year strategy in December 2025 has enabled us to bring together what we have learnt from families, trusts and their staff and stakeholders to focus our priorities and the key areas of work we want to achieve. This has meant we need to challenge ourselves, be ambitious and be the independent voice representative of learning from our investigations.

“Every investigation we undertake reinforces the concept of systems and processes not supporting consistent, high quality, safe care. While our investigation reports are not publicly available, they reflect where learning needs to be focused, alongside where individuals and clinical teams have made a positive impact on families and their experiences.

“Over the last year, we have seen the wider impact of our work within coroners’ processes and a growing confidence to share our learning across different platforms. This ability to share learning in a way that informs and influences care to both an individual or an entire cohort of families is essential and humbling.

“Our work to ensure we fully explore the impact of health equity on outcomes demonstrates the wider societal issues that families are experiencing. Reviewing our work with families to ensure genuine co-design at every stage, inviting scrutiny of our published work, are key steps in our development. The development of a structured coding approach to evidence our thematic learning demonstrates the MNSI team’s curiosity and skill.

“This annual report is reflective of the voices of families who want their experiences to be heard and, most importantly, learnt from. It is reflective of the staff who need support to make the changes and to know they will have a direct impact on safer care. MNSI and other key stakeholders have a responsibility to enable this progress through collaboration and reduced duplication.”



Louise Page
MNSI Clinical Director

“As MNSI Clinical Director, I see first-hand the depth of learning that emerges from the careful and compassionate investigation of safety events in maternity and newborn care. Each investigation reflects the experience of a woman, baby and family, alongside the actions and commitment of the staff involved. It is our responsibility to ensure that these experiences translate into meaningful learning that supports safer care and system-wide improvement.

“This report brings together learning from investigations undertaken during 2025/26, with a focus on the clinical themes that consistently impact outcomes. Recurring patterns include the quality of clinical assessment, recognition and response to risk, fetal monitoring, communication and timely escalation. These themes highlight the complex realities of care delivery and the importance of consistent, evidence-based practice to reduce variation and prevent harm.

“A key and consistent finding across our work is the impact of health inequalities on outcomes. Women and families experiencing disadvantage often face additional barriers within the system, reinforcing the need to identify risk earlier, tailor care and ensure equitable access to safe, high-quality care.

“From a clinical perspective, outcomes are rarely determined by a single decision, but by a sequence of interactions across teams, services and care pathways. Early assessment, access to senior clinical advice, shared situation awareness, and effective multi-disciplinary working are critical to delivering safe care. The strength of MNSI lies in identifying these patterns and translating them into actionable insight that supports learning at local, regional and national levels.

“Through safety recommendations, safety prompts and thematic outputs, this report demonstrates how learning is applied in practice – supporting services to strengthen clinical processes, improve consistency and deliver safer care. This reflects our commitment to collaboration, integrity, excellence and learning, and to ensuring that insight leads to sustained improvement.

“Ultimately, our aim is to support a system where staff are equipped to identify and respond to risk, families are meaningfully engaged, and care is consistently safe, equitable and responsive for every woman and baby.”



MNSI's values



We are effective in maintaining the highest level of excellence



We are supportive of others and value working together to achieve our goals



We will grow and learn as individuals and as an organisation



We act with sincerity, openness, honesty and respect



Highlights of 2025/26

618

Investigations
completed

+1,300

Safety
recommendations

+1,600

Safety
prompts

9

Safety Spotlights
published



Health Equity
Assessment Resource
Toolkit and the Health
Equity Warning Score
**explored health
inequalities in 100%
of maternal death
investigations**



Hosting of our
**second webinar
series**



Partner conferences
attended **covered
10 key topics**



Launch of the
**MNSI two-year
strategy**



**Editorial board
developed** and fully
operational supporting
MNSI publications



The **first COMPASS
programme pilot**
concluded and the
second underway



**Continued involvement in
national initiatives** across
the system including
the Maternity Incentive
Scheme, year eight



**Coding development
work** (to establish themes
within our investigations)
completed and pilot one
launched



Health Equity, Diversity and Inclusion (HEDI) won
'best overall presentation' at the Royal College
of Obstetricians and Gynaecologists (RCOG)
World Congress in London in June 2025

MNSI's impact 2025/26

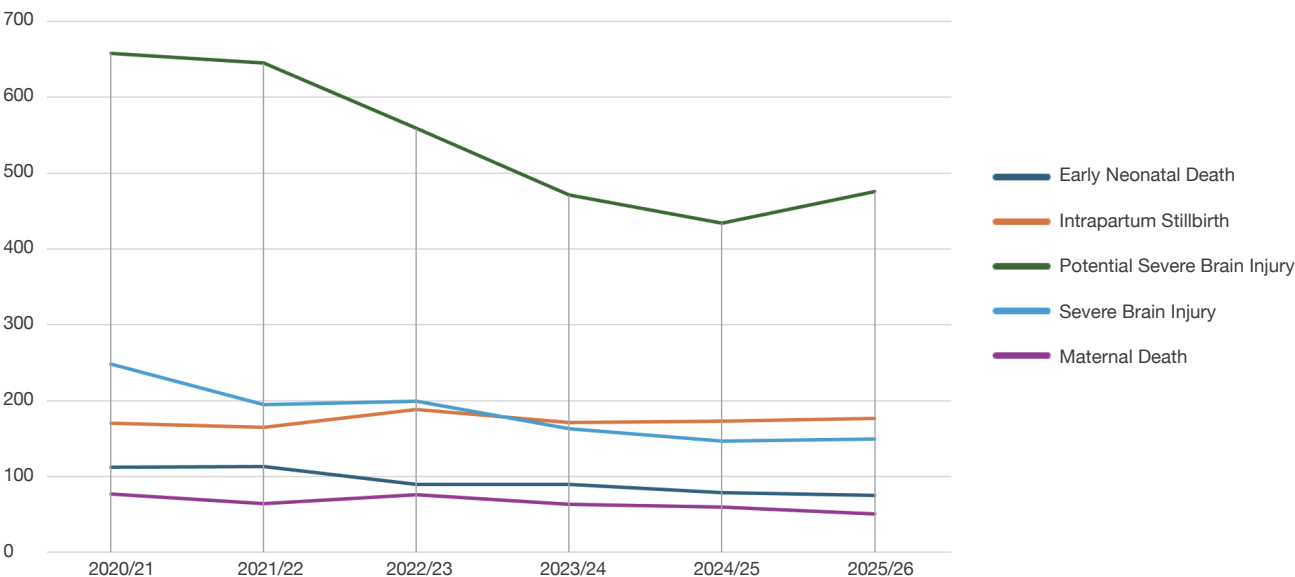
Performance data

During 2025/26, MNSI received a total of 947 referrals, of which 779 met the MNSI criteria for investigation and 168 did not. Of the 779 that met the criteria, 627 progressed to investigation and 152 did not.

Referrals*- annual data

1 April 2020 – 31 March 2026

Number of referrals that met standard criteria



In the graph above, the 'severe brain injury' line is a subset of 'potential severe brain injury' referrals.

Key performance indicator (KPI) performance

MNSI have four main KPIs, three of which consistently met their targets during the 2025/26 financial year.

KPI: Scorecard

At 31 March 2026

KPI Description	KPI Dataset	KPI Dataset Time Period	KPI Target	KPI Outcome
1. Investigations completed within 6-month timeframe (from date of referral)	Investigations (by month referred) that exceeded their 6-month target date by end of March 2026	Rolling 12 months	60%	59%
2. Attempted contact with trusts within 2 working days (from date of referral)	Referrals made in March 2026 that met MNSI criteria	Reporting month	90%	100%
3. Attempted contact with families within 5 working days (from the date permission to contact is granted AND contact details provided)	Referrals made in March 2026 that met MNSI criteria	Reporting month	90%	100%
4. Investigations completed within 6-month timeframe (from date of referral) without exceptions / on holds	Investigations (by month referred) that exceeded their 6-month target date by end of March 2026 , excluding referrals with on hold / exceptions (external delays)	Rolling 12 months	70%	78%

KPI 1: Investigations completed within the six-month target (from date of referral)

We look at this six-month target over a rolling 12-month timeframe. The KPI 1 data looks at investigations referred between 1 October 2024 and 30 September 2025, which would have exceeded the six-month timeframe by 31 March 2026.

- 585 investigations were referred
- 346 (59%) were completed within the six-month timeframe
- 120 (21%) were ongoing between six and seven months at 31 March 2026 (107 completed and 13 active)
- 119 (20%) had exceeded seven months duration at 31 March 2026 (104 completed and 15 active).

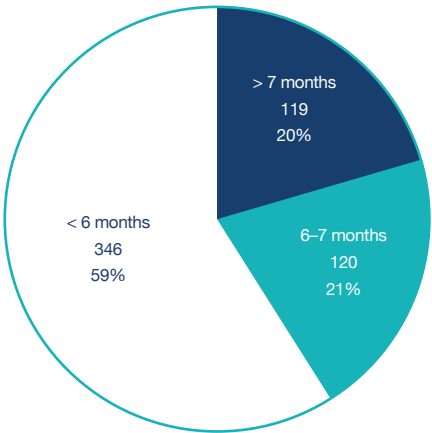
KPI 1: Investigations completed within 6-month timeframe: rolling 12 months

1 October 2024 – 30 September 2025

KPI target: 60%	KPI achieved: 59%
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Notes

- This dataset looks at investigations (by month referred) that exceeded their 6-month timeframe by 31 March 2026.
- 585 investigations were referred in this period.
- 346 (59%) were completed within the 6-month timeframe.
- 120 (21%) were 6–7 months old at 31-03-26 (107 completed and 13 active).
- 119 (20%) were greater than 7 months old at 31-03-26 (104 completed and 15 active)



KPI 2: Attempted contact with Trusts within two working days (from date of referral)

KPI 2 looks at the length of time we take to attempt contact with the trust after a referral is made. This is measured on a monthly basis.

At the end of March 2026, we attempted contact with referring trusts within two working days in 100% of cases, against a target of 90%. The 90% target was achieved or exceeded in every month in 2025/26.

KPI 3: Attempted contact with families within five working days (from the date permission to contact is granted and contact details provided)

KPI 3 looks at the length of time we take to attempt contact with families after they have given permission to the referring trust for us to contact them and their contact details have been shared with us. This is measured on a monthly basis.

At the end of March 2026, we attempted contact with families within five working days in 100% of cases, against a target of 90%. The 90% target was achieved or exceeded in every month in 2025/26.

KPI 4: Investigations completed within the six-month timeframe excluding those with on hold/exceptions (external delays)

Excluding investigations affected by external delays, of the 585 investigations that were referred between 1 October 2024 and 30 September 2025, 225 have been excluded (as they contain external ‘on hold’ or ‘exceptions’).

The remaining 360 included:

- 280 (78%) were completed within the six-month timeframe
- 52 (14%) were ongoing between six and seven months at 31 March 2026 (46 completed and six active)
- 28 (8%) had exceeded seven months duration at 31 March 2026 (25 completed and three active).

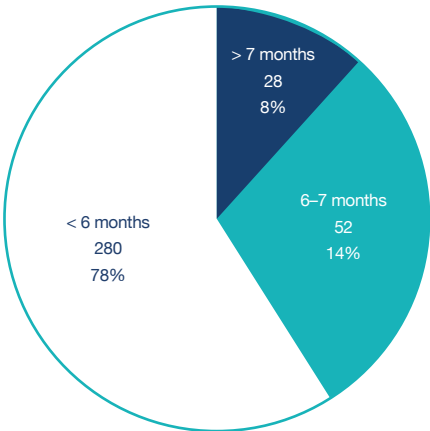
KPI 4: Investigations completed within the 6-month timeframe: rolling 12 months (excluding on hold / exception referrals)

1 October 2024 – 30 September 2025

KPI target: 70%	KPI achieved: 78%
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Notes

- This dataset looks at investigations (by month referred) that exceeded their 6-month timeframe by 31 March 2026.
- 585 investigations were referred in this period.
- 225 have been excluded (as they contain external ‘on hold’ or ‘exceptions’).
- 360 have been included, of which:
 - 280 (78%) were completed within the 6-month timeframe.
 - 52 (14%) were 6–7 months old at 31-03-26 (46 completed and 6 active).
 - 28 (8%) were greater than 7 months old at 31-03-26 (25 completed and 3 active).



In conclusion, 59% of investigations (78% excluding investigations with external delays) were completed within the six-month timeframe; 80% (92% excluding investigations with external delays) were completed within a seven-month timeframe.

Our overall completion of investigations within the six-month timeframe has seen a continued improvement from 40% in 2024/25, to 59% in 2025/26. The programme is completing 80% of investigations within seven months. This dataset includes investigations which are subject to external delays outside MNSI's control (such as police investigations and pending post-mortem examination results).

For investigations to be completed within the six-month timeframe where delays are due to internal operational issues, the KPI has seen a continued improvement from 57% in 2024/25, to 78% in 2025/26. For this dataset, 92% of investigations were completed within seven months.

Overall, this is the highest performance achieved by the team since the programme began, and a credit to the hard work of all team members.

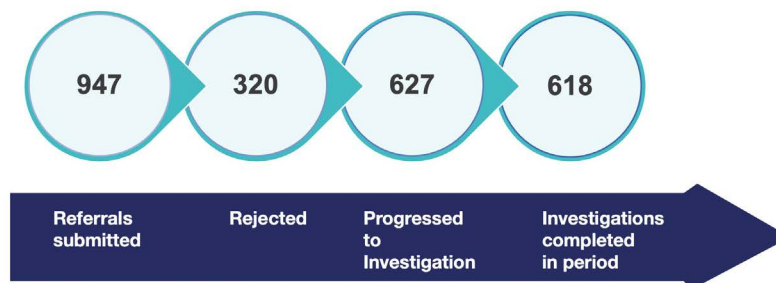
Additional data MNSI collects

Maternity referrals: summary 1 April 2018 to 31 March 2026

Programme to date
1 Apr 2018 – 31 Mar 2026



Year to date
1 Apr 2025 – 31 Mar 2026



From 1 April 2025 to 31 March 2026, there were a total of 779 referrals that met MNSI criteria, about 65 referrals per month. This reflected a 4% increase in the referrals meeting criteria compared to the previous financial year.

The number of referrals progressed to investigation over this period was 627, which reflected a slight increase (4%) in total investigations compared to the previous year.



System-wide impact from MNSI investigations: venous thromboembolism (VTE) (blood clot in a vein)

An MNSI investigation completed in 2023 into a maternal death exposed critical gaps in early pregnancy care across the wider system. The mother, with a significant history of VTE, sought help from her GP early in pregnancy requesting thromboprophylaxis (treatment to prevent the formation of blood clots). Delays in accessing specialist obstetric advice meant treatment was not initiated and she died from a pulmonary embolism (a blockage in a lung artery).

This investigation highlighted system-wide challenges in early risk identification, timely intervention and access to specialist support.

MNSI's safety recommendations focused on:

- Early identification and proactive management of high-risk women, with clear, shared care plans
- Timely initiation of thromboprophylaxis in line with national guidance
- Robust, accessible pathways for urgent obstetric advice across care settings.

Following the 2023 investigation and three-way meeting, and in response to the family's request for wider learning, this investigation has driven sustained national and international impact:

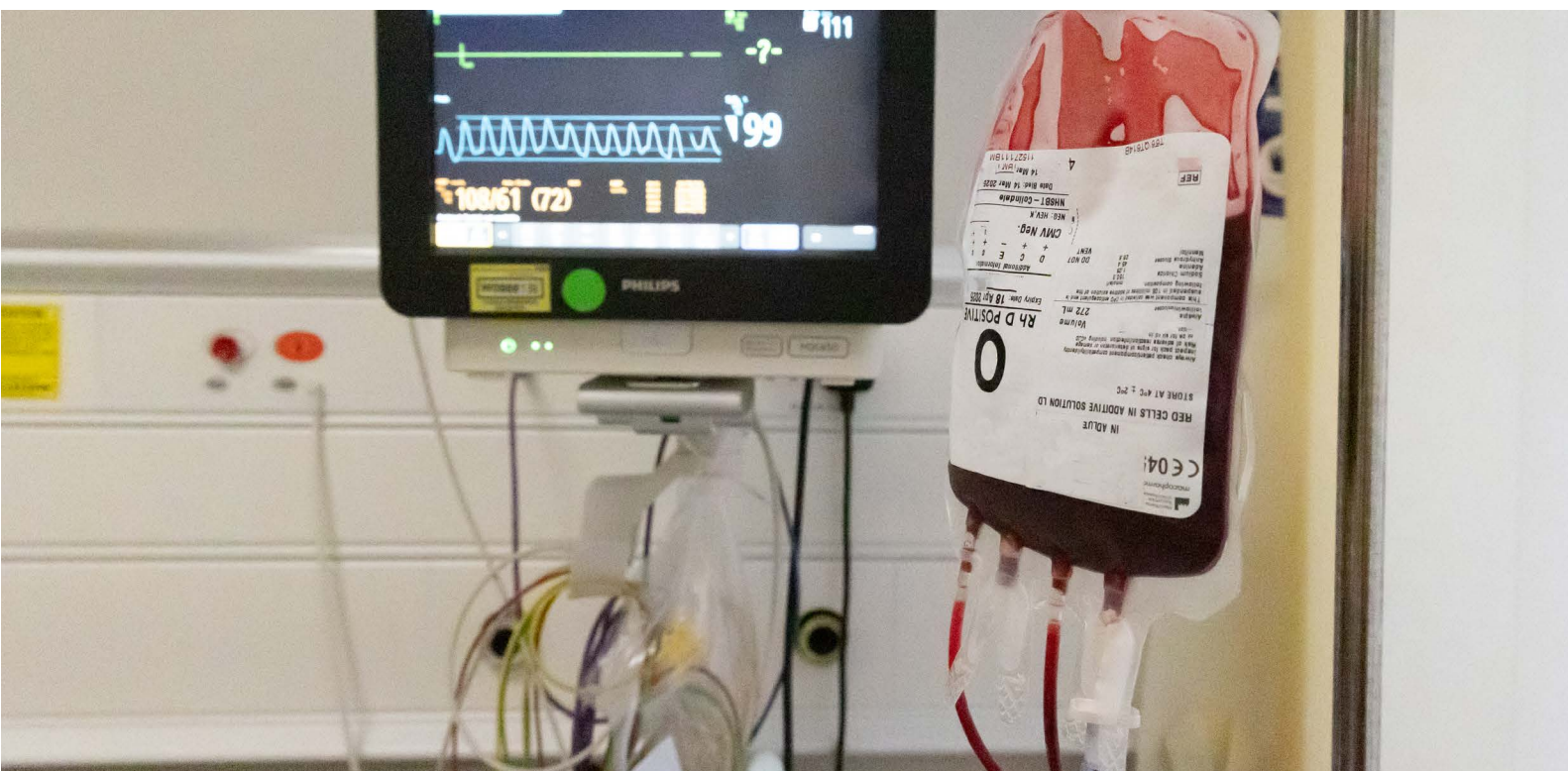
- **October 2024:** informed the 'Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK' (MBRRACE-UK) 'Saving Lives, Improving Mothers' Care' report, strengthening recommendations on early pregnancy VTE management
- **October 2024:** presented at the International Society of Obstetric Medicine (Sydney)
- **May 2025:** British Maternal and Fetal Medicine Society conference (Belfast) poster on first trimester maternal deaths and non-maternity care pathways
- **June 2025:** Royal College of Obstetricians and Gynaecologists World Congress (London) presentation, supporting international learning
- **February 2026:** influenced the NHS England Maternal Care Bundle, including an enhanced early pregnancy VTE risk assessment tool.

This demonstrated how MNSI investigations have led to system-wide improvement, informing national policy, strengthening collaboration and improving care.



System-wide impact from MNSI investigations: exchange transfusion

MNSI identified a critical patient safety risk associated with neonatal exchange blood transfusion. An incorrect infusion line within pre-prepared packs had led to inadequate blood delivery and resulted in significant harm. This investigation highlighted how equipment design, packaging and clinical processes can inadvertently obscure risk. The learning was shared via a Safety Spotlight publication and has been presented at a number of conferences and events including the MNSI stakeholder engagement event. It has informed system-wide improvements across maternity and neonatal services, as seen in the [MHRA alert](#) (May 2026). [The investigation has helped](#) strengthen standardisation, enhance equipment verification processes and reinforce safety safeguards to reduce the likelihood of recurrence.



Deaths in England in the first trimester of pregnancy: Themes relating to non-maternity care provision to mothers

Suzi Jackson, Lorna Sugden and Rachel Rees
 Maternity and Newborn Safety Investigations (MNSI) programme



Background

The 2015 national maternity ambition in England aims to halve maternal deaths by 2025.

Pregnant women in the first trimester pose a unique challenge to healthcare providers due to the unclear accountability of health services in the time between conception and booking for maternity care.

It is imperative to understand factors contributing to deaths in the first trimester so that services, maternal and neonatal outcomes can be improved.

The Maternity and Newborn Safety Investigations (MNSI) programme investigates patient safety events, working closely with staff, trusts and families, aiming to improve maternity safety in England.

Methods

15 first trimester maternal deaths were identified as receiving non-maternity care from completed MNSI investigations between 2019 and 2023; these underwent detailed thematic review.

MNSI promotes the use of the Systems Engineering Initiative for Patient Safety (SEIPS) model (Carayon, 2006; Holden et al, 2013) as one way to help understand why patient safety events occur.

We consider the relationships and interactions between people, tasks, technology and tools, the environment, organisational factors, and national policies and professional guidance, that contribute to how patient safety events occur.

External influences

- COVID-19 - workload pressures, system changes & challenges
- Increased workload in NHS EDs
- Ambulance service pressures & delays
- GPs no longer involved in routine pregnancy care resulting in loss of familiarity

Technology and tools

- GP systems - supporting prescriptions when patients move practice
- Transfer of information between healthcare agencies
- Accessing advice/guidance



Organisation of work

- Clinical oversight
- Senior reviews



Person

- Pre-pregnancy counselling - lack of
- Lack of safety netting advice
- Consideration of predisposing medical conditions, age, BMI, smoking impact on pregnancy



Tasks

- Understanding physiology of pregnancy & appreciation of symptoms
- Perception early pregnancy is safe
- Using correct risk assessment tools: MEWS, PUQE, VTE
- MDT working - joint clinics, access to information/support



Physical environment

- Move to virtual consultations
- Increased reliance of telephone consultations in primary care



Wanted/unwanted outcomes

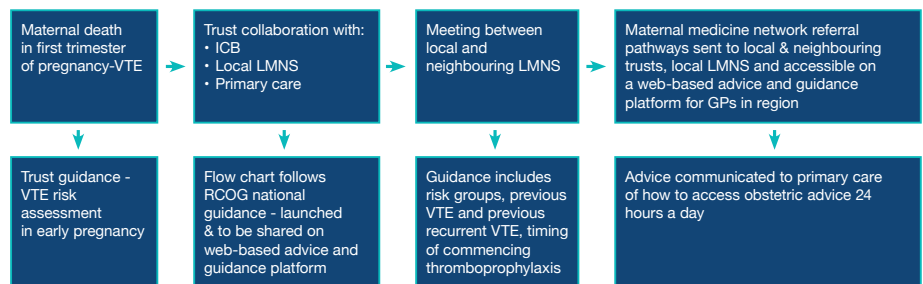
System performance:

- MDT relationships & communication
- Accessible guidance
- Risk assessment tools
- Sharing plans of care

Human wellbeing:

- Pre-pregnancy counselling
- Early referral for obstetric support
- Increased risk of VTE with hyperemesis
- Normalisation of hyperemesis

A collaborative approach to safety improvements





Conclusion / key messages for ICBs and trusts

Across these investigations, we made 28 safety recommendations to non-maternity services within secondary care, pre-hospital & primary care services and integrated care boards (ICBs), and these were the key messages:

- ✓ Primary care providers to take the opportunity to discuss pregnancy plans and/or long-acting contraception with women of childbearing age with existing medical conditions when accessing routine care (e.g. repeat prescriptions, wellbeing checks etc)
- ✓ Specialist obstetric teams and MDTs to communicate future plans clearly with primary care when a woman or birthing person will need early referral or treatment in subsequent pregnancies

- ✓ Healthcare providers (GP, ED) to have access to pregnancy specific risk assessment tools and to ensure that these are completed at every healthcare contact
- ✓ Healthcare providers to understand that these tools need to be used from early pregnancy, as physiological changes take place from the outset
- ✓ Healthcare providers to understand that hyperemesis gravidarum (HG) increases the chance of venous thromboembolism (VTE) in the first trimester
- ✓ Healthcare providers to understand that presumed HG may mask other causes of vomiting in early pregnancy (e.g. neurological)

To find out more about MNSI and our investigations or to attend a webinar discussing this topic further please scan the QR code



Safety recommendations and safety prompts

During 2024/25, MNSI's investigation reports began to include safety prompts as well as safety recommendations. Introduced in April 2024, safety prompts describe a set of questions or prompts for use at a local level. Safety prompts are used where there is not enough evidence to support a safety recommendation, or because the issue fell outside the direct scope of the investigation. Including them in MNSI's reports enables trusts to find solutions when areas of learning have been identified.

MNSI completed 618 investigations between 1 April 2025 and 31 March 2026 and made over 1300 safety recommendations and over 1600 safety prompts. All the recommendations are published on the MNSI website on an annual basis. Where recommendations were made, the average number per investigation report was two. Two codes were assigned to each recommendation identifying broad themes within.

The most frequent themes were:



We are developing a new coding system to increase depth and quality of information that can be extracted from our reports. The system focuses on clinical factors, human factors (based on the System Engineering Initiative for Patient Safety (SEIPS) framework), health, equity, diversity and inclusion, and location (where the event occurred). Each report will be coded following completion.

We intend to retrospectively apply this to previously completed investigation reports following testing and finalisation.

MNSI is also exploring the use of artificial intelligence (AI) using large language models to support coding and development of thematic analysis. As part of this work, we have conducted initial analysis of these recommendations using AI and these themes suggest that the 2024/25 recommendations frequently focused on:

- Clinical assessments and risk evaluations
- Labour and birth processes, especially around fetal monitoring using cardiotocographs (CTGs)
- The importance of escalation protocols and information sharing
- Ensuring systematic processes and support for clinicians
- Emphasis on triage and holistic care.

MNSI is looking forward to working with trusts using the new coding system which will enable the programme to share more detailed analysis of individual reports. This will support ongoing system-wide learning, coding and the continued development of thematic analysis.

The MNSI programme two-year strategy



The MNSI programme is a central part of the national approach to improving safety and outcomes in maternity and newborn care across the NHS. In December 2025, we launched our [strategy](#), providing a clear and purposeful framework to guide the programme's work and strengthen our impact. The strategy is underpinned by a set of core pillars that embed and uphold MNSI's values of collaboration, integrity, excellence and learning, ensuring these principles are consistently applied across all aspects of the programme.

The strategy focuses on supporting NHS trusts to identify risk earlier and act quickly to prevent harm, with a particular emphasis on improving outcomes for communities that experience the poorest care and the greatest health inequalities. Throughout this report, examples are shared to demonstrate how MNSI's work supports these strategic priorities in practice.

Since its inception, MNSI has carried out more than 4,700 investigations into maternity and newborn safety events. Each investigation represents the experience of a family who has experienced loss or harm, and family voices have consistently shaped MNSI's approach. The 2025-27 strategy builds on this foundation by systematically translating insights from investigations into practical, evidence-based recommendations that support safer care and reduce variation across maternity and newborn services.

The strategy has been introduced at a time when England continues to fall short of national ambitions to reduce maternal and infant mortality. Stillbirth rates remain at 3.9 per 1,000 births, neonatal mortality at 1.4 per 1,000 live births, and persistent inequalities in outcomes remain evident. Black women are 2.3 times more likely, and Asian women 1.3 times more likely, to die during pregnancy and childbirth compared with White women. Addressing these disparities is a central feature of MNSI's strategic direction, and this report highlights how investigation learning is being used to inform action on equity and safety.

The strategy is structured around three core priorities:



Excellence in building our internal capacity and governance while sustaining the high investigation quality that defines our credibility.



Impact through harnessing technology and our unique dataset of more than 4,700 investigations to move beyond reactive work toward predictive safety intelligence.



Relationships by embedding authentic family voice, strengthening professional partnerships and fostering system collaboration to drive sustained safety improvements.

- **Excellence:** maintaining the highest standards in independent investigations while strengthening analytical capability and insight
- **Impact:** identifying emerging risks earlier and working across the NHS to support meaningful and measurable improvements in safety
- **Relationships:** ensuring families, staff, and communities shape priorities and influence how learning and improvement are delivered.

A key development within the strategy is the establishment of a new Family Voices Group, which will help guide investigation priorities and embed lived experience across the programme.

This will ensure that family perspectives continue to inform strategy, policies, and processes, strengthening safety, trust and health equity.

The next section of this report illustrates how MNSI's investigations, thematic learning, safety recommendations and engagement activities reflect these priorities in action.

Our strategic priorities

Priority 1: Excellence



Streamline governance: internal review of pillar operating model

The MNSI programme operates through four pillars: Programme Learning and Development, the Operational Delivery Group, the Effectiveness pillar, and the System Learning and Impact Group. An internal review of the model has streamlined ways of working to improve consistency, reduce duplication and strengthen governance. A single framework and clearer pathways for new work now supports more efficient and transparent decision-making. All pillars operate to shared principles, with full adoption of this approach targeted for May 2026 to ensure a consistent and robust programme-wide system.

Build analytical capacity

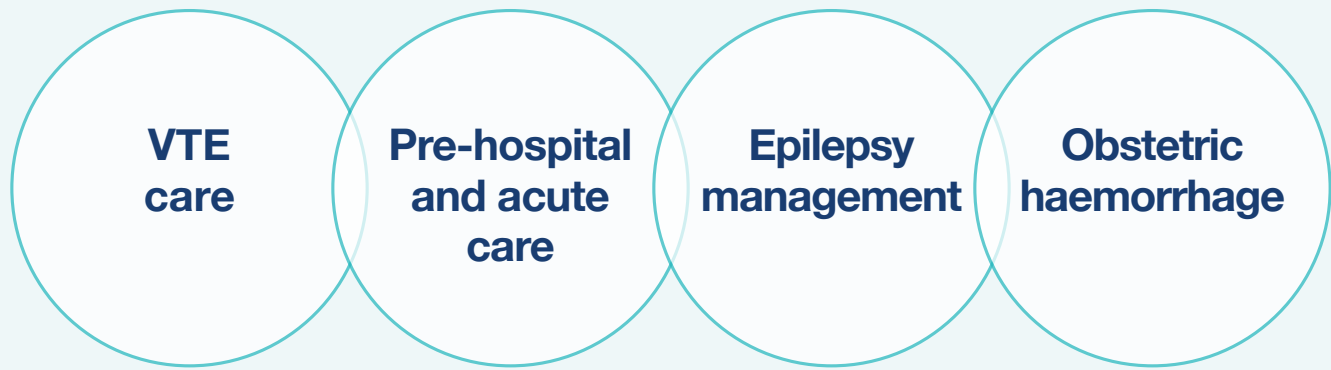
MNSI has further strengthened its analytical capability, with access to seven years of rich data, alongside multi-disciplinary expertise and system-wide partnerships. This has enabled an expanding programme of thematic analysis and collaborative work, with clear and growing influence on learning and improvement across the maternity and neonatal system.

MNSI's published insights, supported by an established webinar series and increasing digital reach are driving impact by enhancing engagement, improving dissemination of learning, and reinforcing our role as a trusted source of intelligence. There is a clear opportunity to build on this foundation by extending the reach and application of existing publications to maximise system-wide improvement.

Demand for MNSI's intelligence continues to grow, reflected in increasing contributions to national reviews, conferences and academic outputs.

Enhanced data integration through the national maternity improvement initiatives – Submit a Perinatal Event Notification service (SPEN) and Maternity Outcomes Signal System (MOSS) – is helping identify risks earlier, improving understanding of the system and supporting stronger, evidence-based safety decisions.

MNSI's impact is also evident in national policy development, with learning from our work informing discussions on the national Maternal Care Bundle. Now established as national policy, MNSI has contributed to four of its five elements.



Related thematic findings have supported this work and have been widely disseminated through e-posters, posters and presentations at key events, including the RCOG World Congress, the Emergency Medical Service Congress and the Baby Lifeline Conference. In addition, the MNSI team is scheduled to deliver an internal teaching session at the Royal Free NHS Foundation Trust focused on the VTE work, further supporting continuous improvement across the maternity and neonatal system.

Standardise quality: feedback and changes to factual accuracy review processes

In late 2025, a review was undertaken of the draft report review process (previously referred to as factual accuracy). This stage of the investigation process is inherently complex and often requires detailed discussion to support shared understanding and quality assure reports.

The review, alongside a subsequent pilot, focused on strengthening clarity, consistency and fairness. During the reporting period, 44 families consented to their feedback being used in other communications and is summarised below, alongside feedback from 202 trust staff.

Family feedback:

- All participating families agreed or strongly agreed that investigator engagement enabled them to feel involved in the investigation and that their perspectives were considered.
- Language needs were identified in 29% of feedback, and in every one of these investigations, families confirmed that suitable interpretation and translation support was provided.
- Feedback consistently highlighted the professionalism, compassion and clarity demonstrated by MNSI investigators. Families described feeling supported and treated with respect during highly traumatic circumstances, with many noting that engagement with MNSI improved their understanding of events and their relationships with trusts.
- Consistent with the MNSI 2024/25 strategy to increase feedback participation and strengthen insight, redesigned feedback surveys for families and trust staff were introduced in early 2026. These surveys are quicker to complete while enabling more meaningful responses to support learning and improvement.

Trust feedback:

- Feedback from trust staff indicates strong confidence in investigator conduct, with 96% of respondents describing MNSI investigators as professional and supportive, enabling open dialogue and clear understanding.
- Feedback also highlighted variation in organisational support, with 55% of respondents reporting they had sufficient time or support to prepare for meetings with MNSI. Additionally, 22% of respondents expressed concerns that MNSI reports could be perceived as apportioning blame or not reflecting family and clinician accounts equitably. This feedback continues to inform work to reinforce consistency, clarity of language and understanding of MNSI's investigative methodology.

Feedback from trusts and families is continuing to enhance confidence in the investigation process and promote equity for all participants.

Enhance operations: on holds and exceptions timeframe review

The MNSI programme's Directions (2023) set the expectation that investigations are completed within six months, where reasonably practicable. While this standard is met in most investigations, delays may arise due to factors outside MNSI's control, including consent processes, access to clinical records, availability of key test results, or alignment with external investigations.

MNSI maintains strong oversight of timelines, reflecting its commitment to integrity, excellence and transparency, supported by strengthened internal processes for the consistent identification and management of delays.

Through collaborative working with trusts and families, MNSI has improved information flows and addressed recurring challenges to reduce avoidable delays. This ongoing focus on enhancing operations, learning and partnership supports the timely progression of investigations. It ensures that insights are shared effectively to inform practice, strengthen safety and drive improvement across the wider maternity and newborn system.

Invest in our people: staff training including continuous professional development

In 2025, MNSI undertook a comprehensive training needs analysis, enabling a more strategic, intelligence-led approach to workforce development and strengthening organisational capability. This directly informed a high-impact programme of learning, embedding a culture of continuous improvement through staff and leadership development, and enhancing safety-focused practice across the programme.

The 2026/27 education strategy will build on this foundation, with a strengthened induction model ensuring all staff are equipped to perform effectively and sustain high standards of performance, reinforcing MNSI's commitment to excellence and investment in its people.

Plans for 2026/27

Our future work will be focused on continual development of the programme, internally in relation to our systems and processes, and externally in relation to providing high quality investigations and thematic learning.

The ability to understand and analyse the information we receive is essential to our work. This is wider than being able to analyse themes from our investigations, it also includes being able to see emerging issues and use our data to inform other pieces of work. Exploring the use of artificial intelligence to support this will enable us to be more efficient with time, reduce the administrative burden within aspects of our work and use staff time to enhance other areas of our work.

We have undertaken work to develop quality assurance processes to support high quality investigations for families and trusts. Further work is required, ensuring feedback is taken into consideration and builds on identified areas of change.

Over the next two years, our approach to recruitment will support accessibility and diversity across our workforce, develop opportunities for progression and support a training approach which focuses on the individual.



Priority 2: Impact



HEWS

Enables early identification of health and social risk factors, generating structured data that enhances national insight and supports the development of predictive, preventative safety approaches

HEART

Complements this by providing an evidence-based framework to understand how inequalities intersect with care, outcomes and family experience.

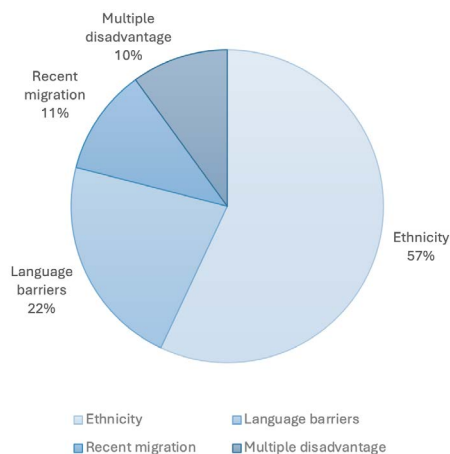
Develop predictive tools: addressing health inequities from the start

Promoting equity and inclusion is central to how MNSI builds meaningful relationships with families and communities. The Health Equity Warning Score (HEWS) and Health Equity Assessment Resource Toolkit (HEART) have strengthened this approach, embedding equity within maternity and neonatal investigations while enabling a more predictive understanding of risk.

These innovative tools, designed in-house, ensure disparities are consistently identified and analysed, with the family voice at the centre, particularly for communities that have historically experienced poorer outcomes. HEWS enables investigators to explore individual circumstances and barriers. HEART provides a robust national and international evidence base, placing lived experience within a wider context. This work has received international recognition, with the HEDI team winning best presentation at the RCOG World Congress in London in June 2025.



THEMES FROM HEDI CLINICS



This structured approach is supported by weekly HEDI clinics, which have engaged nearly 250 investigators in the past year, reinforcing known national risk factors and strengthening the consistency and quality of investigations. Importantly, HEDI input is not only improving investigations but also driving tangible service-level improvements.

For example, in south-east England, MNSI identified digital exclusion as a barrier to accessing maternity information and care. A recommendation led to the introduction of free data-enabled SIM cards for pregnant women without reliable internet access. This enabled access to electronic maternity records, improving engagement, continuity of care and timely access to vital information at no cost to families.

Beyond individual investigations, HEDI tools are shaping wider safety and quality improvement, contributing to initiatives such as the HbA1c and sickle cell Safety Spotlight and NHS Resolution's Maternity Incentive Scheme year eight, strengthening the integration of equity into system-wide improvement.

Impact is already evident at scale: inequalities were explored in 100% of maternal death investigations in 2025, compared to 17% and 4% in previous years, marking a step change in both identification and consistency.

In the future, data from HEWS and HEART will enable MNSI to move from retrospective learning to predictive insight. By identifying patterns and high-risk groups earlier, MNSI is supporting targeted interventions, informing national policy and strengthening the evidence base for system-wide improvement. This work is also being shared widely, with presentations at major forums including the Baby Lifeline Conference, the British Intrapartum Care Society Conference and the RCOG World Congress.

This positions MNSI as a key driver of a proactive, data-informed maternity and neonatal system. We are using insight not only to understand inequalities, but to anticipate and prevent them, ultimately improving outcomes for mothers and babies.

Support the development of early warning systems: SPARC

Over the past year, analytical capability has been strengthened through the development of the Structured Perinatal Analysis Report Coding (SPARC) framework. This bespoke framework has been iteratively developed within MNSI through piloting, refinement and expert review. SPARC captures investigation insights across four domains: (1) health equity, diversity and inclusion, (2) clinical, (3) human factors, and (4) location.

SPARC enables analysis across multiple levels, from high-level themes to detailed contributory factors. In doing so, it moves beyond a sole focus on recommendations, applying a structured, multi-level coding approach to generate deeper contextual insight and supporting continuous quality improvement.

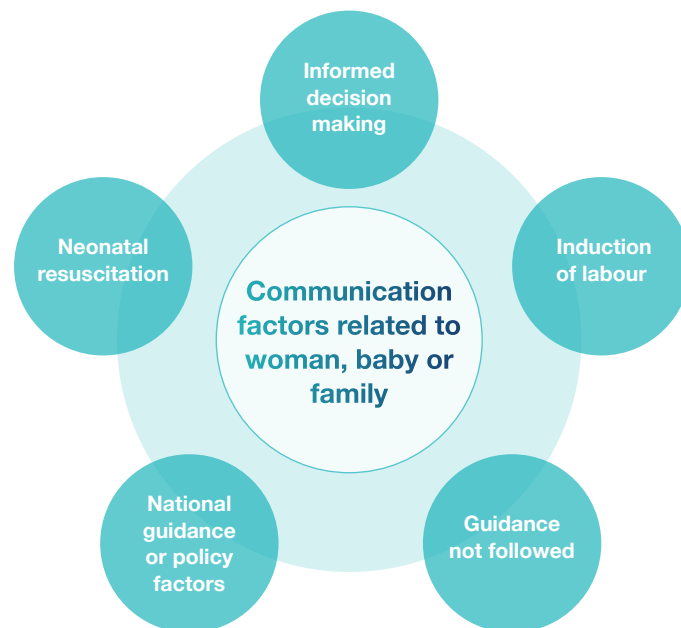
SPARC addresses four needs:

- **Consistency:** supporting standardisation and meaningful comparison across organisations and themes.
- **Insight:** providing richer data to enable a better understanding of the themes arising within MNSI investigations
- **Efficiency:** reducing the time required to review reports, enabling rapid thematic analysis
- **Quality monitoring:** enabling assessment of report depth, consistency and quality

In 2024/25, more than 1,000 recommendations were made. Not all investigation reports contained recommendations, where recommendations were made, the median number per report was two. While our earlier coding system identified common issues such as clinical assessment, escalation, guidance, oversight and communication, this provided only limited detail. SPARC has been developed to address this gap.

Initially piloted on the executive summaries of approximately 200 reports completed in 2025 (including the findings, safety prompts and recommendations), SPARC identified familiar high-level themes including communication, non-adherence to guidance, delays in care and neonatal resuscitation.

It also enabled a more structured, connected analysis by linking primary and related factors. for example, communication factors related to the woman, baby or family were frequently associated with issues in informed decision-making, induction of labour, and guidance not followed – see diagram above.



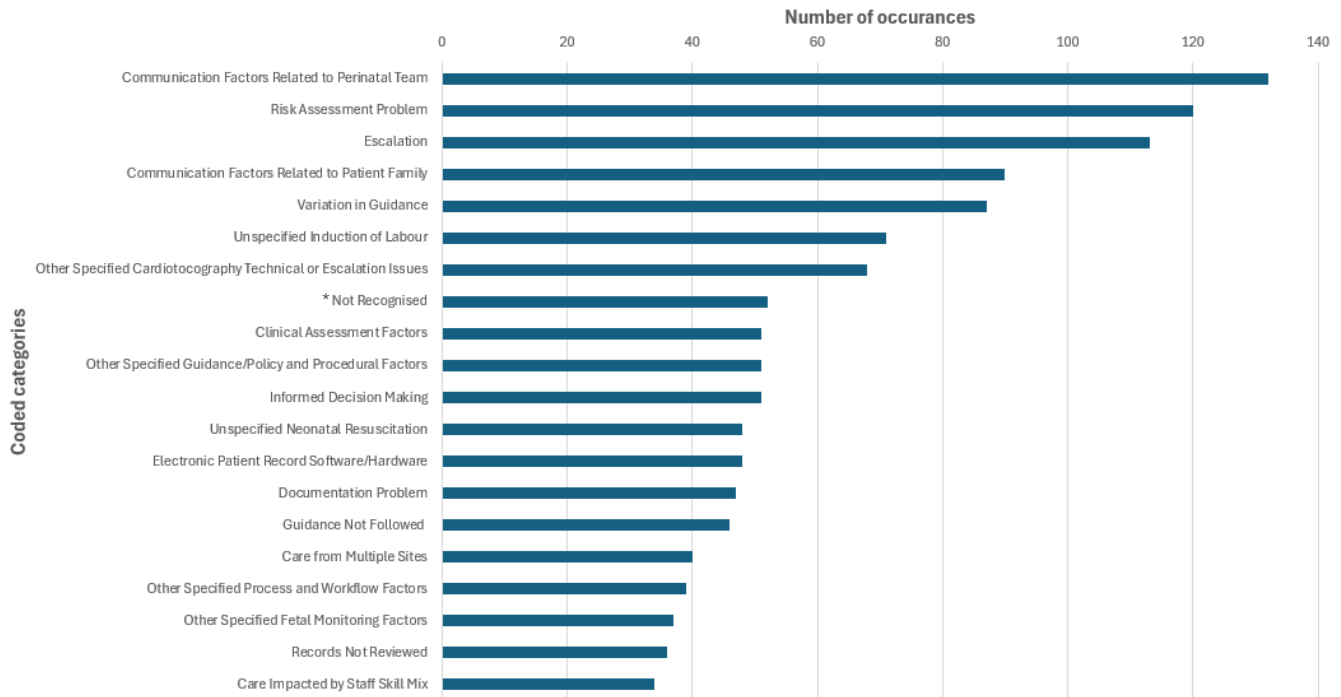
SPARC pilot 2

Building on the first pilot, SPARC pilot 2 analysed a larger dataset of reports completed in 2025/26 - this time solely assigning codes to safety recommendations.

Within this dataset clinical and human factors codes each represented 43% of the codes so accounted for the majority, while location and HEDI codes were seen less frequently. The clinical codes were broadly focussed on themes around labour, fetal monitoring, escalation and triage. Meanwhile human factor codes (based on the Safety Engineering Initiative for Patient Safety (SEIPS) framework) were most commonly associated to organisational type issues (such as communication, culture or guidance), followed by task-related and tools and technology themes.

At the most granular level, we found that communication factors were commonly identified, both in relation to perinatal teams and to families. An example of this was incorporating the voice of mothers within clinical assessments to ensure a full clinical picture. Issues in relation to risk assessments, escalation processes, and variation in guidance were also commonly found (see figure SPARC pilot 2: top level 4 codes).

SPARC Pilot 2: top 20 level 4 codes



*‘not recognised’ is a human factor code in relation to recognition of a situation, for instance not recognising a clinical situation in need of escalation.

When we looked at these granular level 4 codes individually, we found that many issues did not occur in isolation but were clustered together:

- Communication factors within perinatal teams were most commonly associated with escalation, communication and support tools, staffing (skill mix), or neonatal resuscitation issues (see figure below)
- Risk assessment problems were often seen in relation to induction of labour, informed decision-making, and family communication factors
- Escalation issues were closely linked to fetal monitoring concerns and events where problems were not recognised or acted upon in a timely way
- Communication with families was most commonly associated with informed decision-making, risk assessment, fetal monitoring, and induction of labour

Understanding these associations provides a richer and more meaningful picture of how safety risks arise in practice. Rather than viewing issues in isolation, SPARC highlights how different factors interact, enabling more targeted insights and supporting a deeper understanding of the underlying system-wide patterns rather than individual issues.

Building on the successful development and testing of SPARC, the next phase of work will focus on expanding its application and embedding its use across our analysis. This will include coding all executive summaries going forward, creating a more comprehensive dataset to support the identification of trends and emerging issues over time. The growing evidence base will enable the provision of more detailed intelligence to trusts, LMNSs and other stakeholders, supporting local learning and quality improvement activity.

SPARC will also support future thematic reviews by facilitating the rapid identification of recurring themes, contributory factors and relationships between them. As the dataset continues to expand, it will provide increasingly robust evidence to inform learning, track changes over time, and support maternity services in delivering sustained improvements in safety and quality.



Integrate with national initiatives: Maternity Incentive Scheme, year eight

NHS Resolution's Maternity Incentive Scheme (MIS) reporting year seven validation (1 December 2024 to 30 November 2025) was successfully completed for Safety Action 10 across all maternity providers. This confirmed that trusts had met the requirement to report 100% of qualifying events to both the MNSI programme and NHS Resolution's Early Notification (EN) scheme within the reporting period.

The validation process demonstrated consistent compliance with reporting requirements, supporting the overarching objective of improving patient safety through early identification, investigation and shared learning.

Preparations for MIS year eight (2025/26) validation are underway. Year eight introduces a streamlined, outcomes-focused model centred on six core safety actions. MNSI will be involved with the new Safety Action C: learning from reviews and investigations; focusing on ensuring that all qualifying events are identified, reported and investigated through aligned national processes, alongside the EN scheme and the perinatal mortality review tool (PMRT). MNSI's role in year eight will strengthen system-wide learning and help ensure that lessons from adverse outcomes lead to demonstrable improvements in maternity and neonatal safety.

Alongside MIS, ongoing collaborative working between MNSI and the EN scheme continues to strengthen reporting pathways, enhance transparency and accountability, timely investigation of qualifying events, and strengthen system-wide learning.

Plans for 2026/27

Our HEDI work continues to evolve as we contribute a deeper understanding as to why health inequalities persist. MNSI is currently writing a journal article focused on health inequalities, due for publication in 2026/27, further strengthening the academic and evidence-based contribution of our approach.

Since our launch, we have developed important relationships with key stakeholders and had opportunities to collaborate on important pieces of work. Within the current maternity and neonatal arena this is increasingly important. We have a responsibility to collaborate, share our learning and collectively use this to inform change within the system. Building on the work over the last year we will continue to strengthen these relationships and look for new opportunities to collaborate and share learning. The ongoing development of SPARC is key to ensuring the insights from investigations is accessible, robust and high quality.



Priority 3: Relationships



Engage families effectively: Family Voices Group

In line with the MNSI strategic priority on relationships, work has progressed to develop a proposal for the establishment of a Family Voices Group. The group's purpose is to:

- Actively and meaningfully involve service user voices across the MNSI programme
- Ensure that families' perspectives and lived experiences equitably inform the design, shaping, improvement and continuous development of MNSI's strategy, policies and processes
- Have a demonstrable influence on the overall MNSI strategy and on specific areas of work.

An initial consultation with a small panel of families informed the development of proposed terms of reference, recruitment arrangements and role descriptions. This work has established a strong foundation and MNSI will now consider the full proposal alongside the associated financial requirements to support the establishment of the Family Voices Group.

Quotes from families:

- Overall, [person name], my case worker, who investigated the tragic passing of my wife was amazing. Even though it is sad I got to know her under this circumstance, her time, patience and words of encouragement helped a lot and I can't thank her and the whole MNSI team enough.
- We would just like to put it on record that [person name] and [person name] have been fantastic and we have felt they are the only positive from our traumatic

situation. MNSI is the only meaningful process we have found along this journey, and we are truly grateful for the objective facts and answers they have found. Whilst maintaining the utmost professionalism and still speaking to us and treating us like human beings through the hardest time of our lives. Something we seldom see with other departments/healthcare professionals.

- We feel that the MNSI played a critical role in helping us understand the traumatic event we went through. They really do a fantastic job in helping people in these situations and I would recommend all couples to engage with their services.
- [Person name] was very understanding and supportive throughout, particularly in the early stages just a few weeks after we'd lost [person name] and made the process as easy as it could be (still very difficult!) We don't think there's much they could have done better and we are very grateful for that. Early on we were in two minds about whether to proceed with the investigation at all, but we're glad we did. Our relationship with the hospital is improved and they have seemed receptive to feedback - it was difficult to imagine either late last year.

Quotes from trusts:

- I was made to feel extremely comfortable when attending the Teams interview as the staff were very friendly and reassuring throughout the whole process.
- I have been involved in two MNSI investigations and both were positive experiences. I was extremely nervous about these, but the investigators were very friendly and put me at ease. They were also very accommodating around my shift pattern when planning this interview.
- Thank you again so much for sharing. I also wanted to take the opportunity to thank you for the supportive environment that you and your team created throughout this investigation. My staff never felt so supported, even during such a difficult time, and it truly made a difference for them.

Promote equity and inclusion: COMPASS

Building on the positive response to an initial pilot in 2025, MNSI further developed and embedded COMPASS (Culture of Organisations and its iMPact on PATientS' Safety). This patient safety tool assesses the influence of organisational culture on maternity and newborn care. COMPASS was developed in response to 'Responding to Challenge', a Patient Experience Library literature review identifying organisational culture as a key contributor to avoidable safety events.

The initial aim was to establish whether COMPASS could reliably capture cultural observations, quantify them meaningfully and provide actionable insights. The first pilot, in April 2025 across 12 NHS trusts, demonstrated that cultural insights could be shared within a psychologically safe environment, supporting open dialogue on how culture impacts safety and surfacing previously unrecognised issues. Importantly, structured feedback either improved or did not negatively affect relationships, enabling broader perspectives on safety and culture.

Findings from the COMPASS pilot have attracted interest from national stakeholders, including the perinatal culture and leadership programme steering group, Health Services Safety Investigation Body, NHS Resolution and international organisations such as the Asia-Pacific Patient Safety Network.

Learning from the initial phase informed refinements to the COMPASS methodology, now implemented in a second pilot across 29 trusts. To date, more than 200 cultural observations linked to patient safety have been collected, allowing the enhanced tool to be tested at scale.

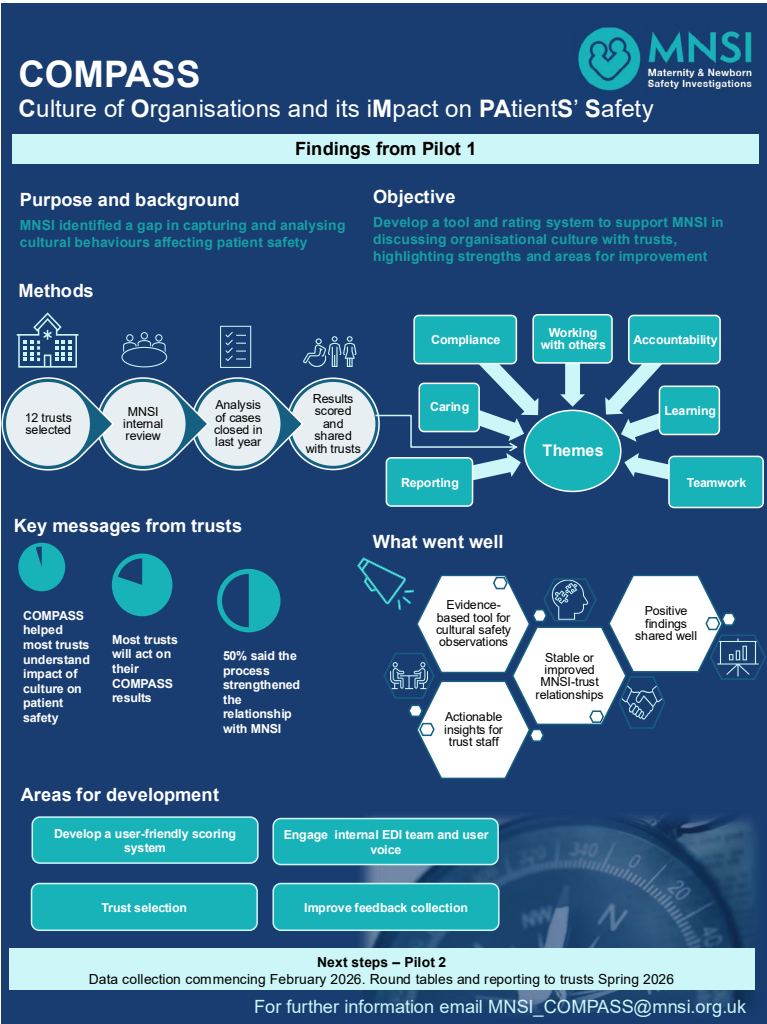
This phase introduced contemporaneous cultural observations, providing timely insights to support early discussion of emerging findings. A revised rating system improves clarity and helps define what 'good culture' looks like in practice. The goal is for COMPASS to support trusts in monitoring cultural progress, identifying emerging risks earlier and acting as a regular 'temperature check' to prompt timely review and escalation.

Pilot outcomes will inform future ambitions, including external validation, wider adaptation and system-level learning to strengthen patient safety.

Strengthen collaboration: Editorial Board

MNSI has established a multi-disciplinary [Editorial Board](#) to strengthen the quality, consistency and accessibility of its publications. Bringing together 12 external experts from maternity, neonatal, legal and healthcare backgrounds, the Board helps ensure MNSI outputs are clear, accurate and relevant for the wide range of professionals and organisations that rely on them.

By embedding stakeholder perspectives earlier in the publishing process, the Board supports the production of guidance and learning that is more inclusive, credible and usable across the maternity and newborn system.





While MNSI retains full editorial control, this collaborative approach enhances confidence in our publications and supports more consistent learning and improvement across NHS maternity and neonatal services nationwide.

From launch in January 2026 to end March 2026, Board members have supported the publication of six Safety Spotlights. They are also currently contributing to the development of two further briefing papers and four additional safety spotlights.

Lead in the system

Since inception, MNSI has completed more than 4,700 standardised perinatal investigation reports – likely the largest collection of its kind globally. This is creating a powerful evidence base to identify recurring risks and inform system-wide safety improvement. MNSI actively expands its influence by identifying emerging risks through targeted thematic reviews, including maternal deaths, neonatal resuscitation, and care in midwifery-led units, ensuring learning is timely, relevant and shared across the system.

In 2025/26, MNSI has continued to disseminate learning through bulletins, Safety Spotlights, briefings, blogs, webinars, conferences, and enhanced publications, published on our [website](#), supported by our Editorial Board.

MNSI has strengthened collaboration with universities and system partners by sharing our data sets to support deeper thematic analysis and system-wide learning. During 2025/26, MNSI partnered with:

- Obstetric Bleeding Study UK (Cardiff and Vale University Health Board) to review learning from maternal deaths with obstetric bleeding. This work was presented at BICS 2025. We are planning further publications and a webinar in 2026.
- University Hospitals Coventry and Warwickshire, University Hospitals Birmingham and the Rugby Air Ambulance Service to learn from out-of-hospital cardiac arrest and resuscitative hysterotomy. This has been published as a briefing paper in 2025 and presented at conferences.
- Ambulance services to share learning from maternal deaths involving pre-hospital care and now reviewing out-of-hospital neonatal care.
- Upskill Health: early 2026, MNSI partnered with Upskill Health in a pilot to support bite-sized, on-the-job training for busy clinicians through a digital platform combining mobile, AI and virtual reality technologies.

IMPACTED FETAL HEAD: Learning from a thematic review of safety investigations

Authors: Lorna Sugden, Rebecca Georgiou, Suzi Jackson, Nikki Jackson, Makani Purva, Paul Mannix, Louise Page



OBJECTIVES

Our aim was to analyse completed MNSI safety investigations to review any themes where there has been evidence of impacted fetal head during unplanned caesarean birth.

METHOD

A qualitative thematic review evaluated work system factors influencing the management of impacted fetal head (IFH) at caesarean birth (CB), based on the findings and safety recommendations from 78 completed investigations (April 2019 - January 2025).

The Systems Engineering Initiative for Patient Safety (SEIPS) was used as an inductive framework for the analysis.

 Handover of the mother's care was not undertaken using a structured tool, and key pieces of information were not included.

 Staff explained that IFH is diagnosed at the point of birth, and IFH as a risk factor is not routinely discussed during labour.

 We found there were opportunities to strengthen the recognition and escalation of cumulative risk factors associated with an increased likelihood of caesarean birth and potential complication.

 The impact of the baby's head, and difficulty in the birth, was not anticipated which led to the obstetric consultant on call not being asked to attend the birth. This meant that the support and oversight of a senior obstetrician during a complex birth was not available.

 Variation in techniques used to manage IFH highlighted the importance of a shared, stepwise approach in the operating theatre.

 When the difficulty in birthing the baby's head was identified, it was common for the obstetrician to be task focused which led to the emergency not being declared to the wider team.

 There was often no local guidance or training to support staff in the management of complications during CS.

CONCLUSION

The review identified recurring themes that contributed to unintended outcomes for babies:

Anticipation of IFH:

- Limited labour assessment, inconsistent documentation, and differences in staff experience make anticipation harder.
- Pressures, competing priorities, staffing shortages, and communication gaps delaying escalation and readiness for potential IFH at CB.

Management of IFH at CB:

- Staff usually recognised and managed IFH with accepted techniques.
- Training, experience, and preferred methods varied. There was limited standardised training and approaches, made harder by the complexity of IFH.
- Management was also affected by task focus, team readiness, and communication issues.

Reference:
Carayon, Woodbridge, Hoonakker, Hundt, and Kelly. (2020) SEIPS 3.0: human-centred design of the patient journey for patient safety. Applied Ergonomics, 84, 103033.

To find out more about MNSI and our investigations or to attend a webinar discussing this topic further, please scan the QR code

 enquiries@mnsi.org.uk  www.mnsi.org.uk



MNSI webinars have proven an effective mechanism for amplifying learning and engaging a broad multi-disciplinary audience.

Webinar topics in 2025/26 included:

- Neonatal resuscitation
- Birthing outside of guidance
- Health Equity Warning Score (HEWS) and the Health Equity Assessment and Resource Toolkit (HEART)
- Factors affecting the delivery of safe care in midwifery units
- Umbilical cord management.

MNSI increased our safety communications in 2025/26, compared to the previous year, to rapidly share key safety messages and emerging risks with all providers for consideration within local maternity and neonatal services. Published Safety Spotlights included:

- Newborn cooling practices
- Late diagnosis of breech presentation
- Exchange blood transfusion.



MNSI has presented at many conferences during 2025/26, covering 10 different topics to share learning. MNSI representatives at conferences included maternity investigators, clinical advisors, programme leadership team, heads of region, team leaders and clinical fellows. Highlights included:

- RCOG World congress: a plenary on system safety, multiple posters
- British Intrapartum Care Society: workshop on health inequalities, multiple posters and oral presentations
- British Journal of Midwifery: invited speaker on birthing outside of guidance
- BAPM and RCPCH: presentations on newborn care
- BMFMS-Society lecture: lessons from the MNSI programme.



Plans for 2026/27

MNSI will deliver a programme of Safety Spotlights including nitrous oxide in maternity theatres, care on non-maternity wards, and the use of '2222' emergency calls. Briefing papers will be published on therapeutic cooling practices, remote hospital working and learning from when there has been an impacted fetal head.

Homebirth has been identified as a key development area. Building on learning from investigations, MNSI is undertaking this thematic review (initiated in 2025) to better understand how systems and care pathways influence the safety of intrapartum care at home. This work has gained significant media interest following a coroner's inquest and Prevention of Future Deaths report in November 2025, relating to events independently investigated by MNSI. Findings from the review are expected to inform national work led by NHS England to support the safe delivery of homebirth services.

Electronic patient records will be a focus to understand how they may impact on safety events, and we expect publication of this thematic review later this year.

MNSI will continue to strengthen our impact through collaborative partnerships, including with Royal Colleges, specialist societies and national reviews such as the Amos Review and subsequent taskforce activity. International engagement will expand, including ongoing collaboration with safety review organisations in Japan.

Finally, MNSI is developing a standardised process for trusts to share actions and learning from investigations, which will be published on our website.

Conclusion

This report showcases MNSI's progress and achievements, from delivering excellence in investigations to strengthening our role in collaborative safety leadership. Underpinned by values of collaboration, integrity, excellence and learning, and enabled through our developing strategic pillars, we continue to evolve our approach to improving maternity and newborn safety.

In March 2026, the Department of Health and Social Care confirmed that the MNSI programme will continue until at least 2030, thus providing a significant opportunity to extend the impact of our work. This will enable MNSI to build on our growing evidence base, fully deliver the 2025-27 strategy, and go further in ensuring that learning from investigations reaches more trusts, informs national policy and contributes to reducing inequalities in maternity and newborn care across England.

As the strategy matures, MNSI is striving to be recognised as the definitive voice in this field, valued not only for the rigour of our investigations, but for the ability to translate learning into actionable intelligence that drives meaningful, system-wide improvement. Above all, it reflects MNSI's unwavering commitment to ensuring that every woman, birthing person and baby in England receives the safest possible care.



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