**From:** Maternity and Newborn Safety Investigations
**To:** Corinne Harrison
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The leading body for maternity and newborn safety investigations in England

# May 2024

A monthly bulletin for stakeholders, clinical and non-clinical staff working in maternity care and patient safety.

## National learning report highlights key factors needed to ensure safe care in midwifery units

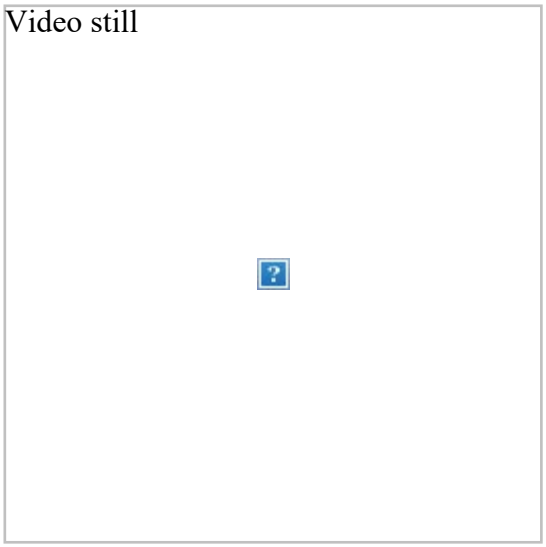
Learning

On May 8th 2024, we published a report identifying the main factors affecting the delivery of safe care in NHS hospital midwifery units.

The report – '*Factors affecting the delivery of safe care in midwifery units'* – looks at the findings from 92 of our investigations where safety recommendations were made to midwife led units in NHS hospital trusts in England. It highlights key learnings and prompts to help trusts to consider how safety risks can be mitigated and drive improvements in care.

**Read our report**

# Family and staff information videos




We've added information videos for families and staff about the MNSI investigation process to our overview pages.

These videos can be shared with staff or families, so they have a better understanding of what to expect and can hear from those that have already taken part in an investigation.

**Watch the staff video**

**Watch the family video**

# Safety spotlight

MNSI has undertaken investigations of maternal deaths in the first trimester from venous thromboembolism (VTE). Two recurrent features in these investigations are:

1. Significant first trimester nausea and vomiting
2. Immobility, which may be a consequence of how poorly mothers are with the nausea and vomiting

- When a mother with nausea and vomiting presents in your department, do you use the PUQE score to assess the grade of nausea & vomiting to determine the impact of this on their VTE score?
- Is immobility explored, assessed and considered within the VTE risk assessment?

**Read RCOG guidance**

# Other news

Researchers at the Manchester Stillbirth Research Centre would like to speak to

MNSI responded to the report by the All-Party Parliamentary Group on Birth

parents who have taken part in an MNSI investigation, or had their case reviewed using the Perinatal Mortality Review Tool, since Jan 2019. They would like to understand parents' experiences of the review process and the research will help inform policy in this important area.

They are particularly keen to hear from non-White women and women from less affluent backgrounds.

Please email matrep@manchester.ac.uk to take part.

Trauma.

The Royal College of Midwives launched a tool to tackle high levels of maternity disadvantage.

Sands and Tommy's Joint Policy Unit published the second Saving Babies' Lives Progress report.

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# Upcoming events

- 12-13 June: NHS Confed Expo (info here)

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mnsi.org.uk