MNSI Stakeholder Bulletin, November 2024

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The leading body for maternity and newborn safety investigations in England

November 2024

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

MNSI annual report 2023/24 published

MNSI's Annual Report 2023/24 has been published today, 7 November 2024.

The report shines a light on the work MNSI has undertaken in 2023/24 and shares the programme's ambitions for 2025 and beyond.

Over the past year MNSI has continued to focus on ensuring that all mothers/birthing people and their families can access safe maternity services in England, opening over 600 new maternity safety investigations in 2023/24.

Across 2023/24 we have worked to:

- Reduce the inequity of outcomes for Black / ethnic minority women / birthing people and their babies.
- Improve communication between mothers/birthing people and maternity services.
- Improve the impact of thematic learning information.

The report highlights our progress in these areas and areas for future development.

The report also shines a light on the impact our work has had on the women/birthing people and their families who participate in our investigations. We repeatedly hear their hope that no other family goes through what they have experienced; we 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.

Read our full Annual Report 2023/24 here

Louise Page and Julian Sutton at the ISOM SOMANZ Joint Congress

ISOM - SOMANZ Joint Congress 2024

In October we had the honour of attending and presenting at the ISOM-SOMANZ Joint Congress 2024.

The Congress is an opportunity for leaders in obstetric medicine to collaborate and share best practice and learning.

We presented our research into “Deaths in England in the first trimester of pregnancy: national patterns and safety recommendations”.

We also had the opportunity to exhibit four posters showcasing several areas of research we have undertaken. Topics included (click the links below to view the posters):

- Think beyond sepsis
- Review of Maternity and Newborn Safety Investigation Report following maternal death from pulmonary embolism
- Learning from maternal Sudden Unexplained Death in Epilepsy (SUDEP): Thematic analysis of safety investigations in England
- First trimester deaths in England from venous thromboembolism associated with hyperemesis: Learning and safety prompts

Louise Page, Interim Clinical Director at MNSI who attended the conference on behalf of the programme said: “It was an honour to attend and present our research the ISOM-SOMANZ Joint Congress 2024.

“As a maternity safety programme we are always looking to extend the reach and impact of our maternity safety investigations and the thematic learning identified through them.

“Presenting at the ISOM-SOMANZ Joint Congress gave us an international platform to share our knowledge and insight, as well as gathering best practice from colleagues across the globe to share back home.”

MNSI will be presenting a series of webinars based on the items presented at ISOM-SOMANZ 2024.

Sign up here to join the Webinar waitlist

Safety prompts

Safety prompts within MNSI investigation reports

On 1 April 2024, we introduced changes to our investigation reports and processes. These changes have been made to support a culture of excellence and increase the impact and reach of our maternity safety investigations.

Many trusts are receiving the new style investigation reports which now include safety prompts alongside our findings and recommendations.

Safety prompts describe an action that may help to improve safety at a local level but where there was insufficient evidence to support a formal safety recommendation, or where the issue fell outside the direct scope of the investigation. The creation of safety prompts allows trusts to consider the risks identified and be at the centre of creating solutions, providing additional opportunities for learning and development.

You can read more about our safety prompts at the link below.

Click here to read the Safety prompts briefing

Safety spotlight

Prescribing and dispensing of low molecular weight heparin

A pregnant mother was seen outside of the maternity service and was prescribed low molecular weight heparin, the prescription did not contain essential information to allow pharmacy checks to be completed. This led to incorrect doses of low molecular weight heparin being dispensed by the pharmacy to a pregnant mother. To minimise this happening in your service, consider the following:

- When low molecular weight heparin needs to be prescribed, does the electronic or paper prescription chart ask for the patient's weight, their renal function, indication of treatment, and the length that treatment is needed for?
- Do electronic prescription charts have mandatory fields to make sure that this essential information is provided before the prescription can be generated?
- Does your pharmacy team ask for this essential information to be provided if it is not included on the prescription chart?
- Is your pharmacy checking processes for low molecular weight heparin the same for all patients across the trust?
- Do you carry out audits on weight-based dosing of low molecular weight heparin?

Other news

MNSI response to CQC State of Care Report

In October the Care Quality Commission (CQC) published their annual State of Care Report. You can read our response to the State of Care report at the link below.

Read the MNSI response to the State of Care report here

Dash review update

The Secretary of State for Health and Social Care announced in October that a review into patient safety and effectiveness would be undertaken by Penny Dash following the publication of her review into the operational effectiveness of the Care Quality Commission (CQC). The review will examine the roles and remits of six key organisations including the CQC and the MNSI Programme.

Read our response to the Dash review here

Upcoming events

14 - 15 November: British Intrapartum Care Society Obstetrics (BICS) Conference

15 November: Association of Child Death Review Professionals Annual Conference

6 December: MOMS Annual Meeting

Various: Exploring Learnings from MNSI Investigations - webinar series, click here to join the waitlist to receive more info when dates have been set

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mnsi.org.uk