NHS Resolution

Safety Action C – Learning from investigations

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Safety Action C
Learning from Reviews and Investigations

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Safety Action C – Learning from reviews and investigations

The ‘what’ - outcome

- Effective Board oversight of thematic learning and progress with actions arising from local and national reviews and investigations of adverse incidents.

The ‘why’

- The focus of this Safety Action is to ensure that every perinatal and maternal death, and every baby with the potential for severe brain injury, is consistently identified, investigated, and learned from using the appropriate local and national processes.
- Multiple investigations and enquiries have identified failures to robustly investigate and learn from perinatal deaths, baby brain injury, maternal deaths and patient safety incidents.
- This highlight the need for trusts to move beyond MIS process compliance, to learning from PMRT, MBRRACE-UK, MNSI, NHSR EN, MOSS and other national reports that is then actively used to drive change.

Safety Action C – Learning from reviews and investigations

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The ‘how’ – 6 core standards - what do you need to do

- Review and reporting (3)
- Sharing information with families (2)
- Learning and governance (1)
- What good looks like – supplementary guidance

The ‘how’ – core standards - what you need to do

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Reporting and Review

1. Notify all qualifying events All eligible events must be notified through the NHSE Submit a Perinatal Event Notification (SPEN) portal to MBRRACE-UK, NHSR EN and MNSI as soon as possible after the death/diagnosis.

Notification: Timeline requirement removed*, but since everything else follows from event notification it is essential that notification is timely; SPEN de-duplication will help

* Note that notification of **neonatal deaths** to MBRRACE-UK is the route to notifying local CDOP via Cascade and the statutory deadline for notification is **two working days for these deaths**

The ‘how’ – core standards - what you need to do

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Reporting and Review

2. Seek parents’ views of care For the deaths of all babies in your trust eligible for PMRT review ensure parents are given multiple opportunities to meaningfully provide their experience of all elements of care and the impact of that care and raise any questions and comments they may have prior to the PMRT review starting.

Purpose of reviews: To provide bereaved parents with a timely explanation of what happened with their care, why their baby died, whether different care may have resulted in a different outcome, and whether there are any implications for their care in future pregnancies. For trusts to identify and implement learning to improve future care for all mothers and babies.

Parents have the greatest stake in understanding what happened to their baby – they may have questions and concerns which can only be addressed in the review if you ask them

The ‘how’ – core – standards what do you need to do

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Reporting and Review

3. External multi-disciplinary reviewers For a minimum of 60% of the deaths reviewed, external members of relevant specialties must be present at the multi-disciplinary review and this should be documented within the PMRT.

> The external member(s) is/are present to provide an independent ‘fresh pair of eyes’ to the review of the care provided, to actively participate in the review discussion and to provide robust clinical challenge where required. To do so they must be from relevant clinical specialties, e.g. obstetrics, neonatology.
>
> Parents value highly the independence of review that comes with the involvement of externals; otherwise trust are seen as “marking their own homework.”[1]

1. *MATREP* evaluation, University of Manchester 2025

The ‘how’ – core standards what you need to do

Reporting and Review

Practical tips for NHS Resolution Early Notification (EN) Scheme reporting

1. Notify all qualifying events All eligible events must be notified through the NHSE Submit a Perinatal Event Notification (SPEN) portal to MBRRACE-UK, and MNSI as soon as possible after the death/diagnosis.

Notification: Timeline requirement removed, but since everything else follows from event notification it is essential that notification is timely; **For cases that are eligible for EN Scheme** complete part 2 of SPEN as soon as MNSI have confirmed their rationale to proceed with investigation **and / or** as soon as MRI report confirming diagnosis of brain injury is available

External verification of EN Scheme reported cases will continue in MIS year 8

The ‘how’ – core – standards what do you need to do

Sharing information with families

4. Provide relevant information

Provide relevant information regarding the role of MNSI, NHSR EN scheme and PMRT reviews to families in a format that is relevant and accessible to them. Information about duty of candour must be provided for all parents where the event is eligible for duty of candour.

- Clear, accessible written and verbal information available for parents explaining MNSI, the EN scheme and the PMRT process.
- Materials provided in different formats, ensuring families have been asked how they would like to receive information, so they understand what is happening . This may need to be offered more than once and feedback from families received to inform opportunities to improve how this is undertaken.
- Duty of Candour is undertaken and clearly documented.
- Confirmation through Board assurance that the right information is received at the right time and any gaps are identified.

The ‘how’ – core standards: examples of what good might look like

Sharing information with families

4. Provide relevant information

Provide relevant information regarding the role of MNSI, NHSR EN scheme and PMRT reviews to families in a format that is relevant and accessible to them. Information about duty of candour must be provided for all parents where the event is eligible for duty of candour.

- Written and verbal information explaining MNSI, the EN scheme and the PMRT process; offered in a sensitive and timely way, with parents signposted to relevant resources offered from each organisation
- Materials provided in different formats, including, but not limited to: ‘Easy-read’, translated versions, or interpreter-supported conversations, aligning with sub-action D1) to ensure families with language or communication needs can understand what is happening.
- Evidence that information is offered more than once (aligning with sub action C2) so families have multiple opportunities to ask questions or share their views before the PMRT review begins.
- Duty of Candour conversations and letters documented clearly, with families given time, support and contact details for follow-up.

External verification of Duty of Candour for the EN Scheme will continue in MIS year 8

The ‘how’ – core – standards what do you need to do

Sharing information with families

5. Offer parents a meeting with relevant specialists

Offer parents a meeting with relevant specialists to share the findings with them from reviews and investigations, and relevant incident reports.

- Proactively offer families a meeting with clinical specialists who are able to talk through the findings and answer the families' questions.
- Think about where this takes place and ask the family how this can be best supported.
- This may need to be offered and undertaken more than once
- Follow up the conversation and any agreed actions

The ‘how’ – core – standards what do you need to do

Learning and governance

6. Thematic reports of learning and actions

The Trust must produce thematic reports that summarise learning and progress on actions arising from MNSI and NHSR EN reports, local PMRT and PSIRF reviews, MOSS critical safety checks, NHSR claims scorecards and relevant national reports. Trusts must also use demographic data to identify and understand any disparities in outcomes.

- These quarterly thematic reports must be reviewed with the Trust Perinatal and Board level safety Champions and submitted to the Trust Executive Board.
- They need to bring together learning and actions across all relevant sources that inform safety
- Consider demographic data to inform disparities and areas of inequality
- Identify actual or emerging themes
- Indicate how learning has been shared across the relevant teams
- Evidence actions and impact
- Support constructive check and challenge

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Safety Action C – Learning from reviews and investigations

Using the scorecard to contribute to thematic reports

Safety & Learning Team

Aim of this presentation

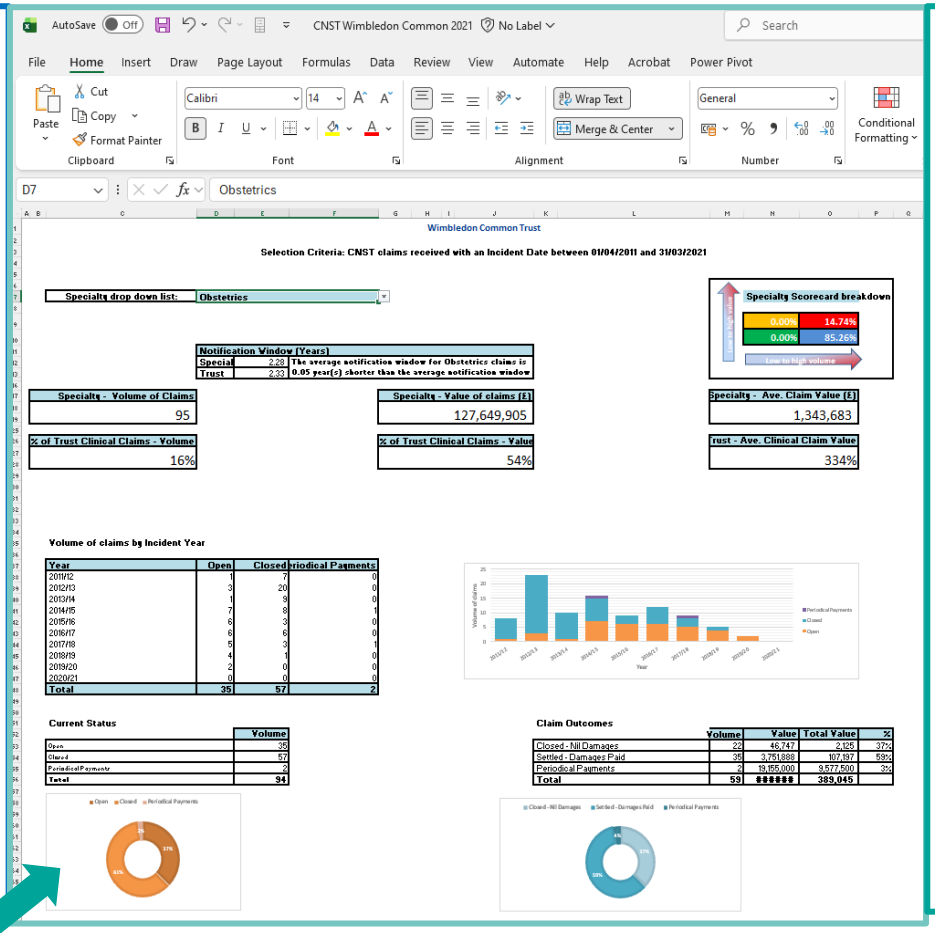
To provide an overview of the Clinical negligence for Trust (CNST) claim's scorecard and how to use it to create thematic reports for learning & actions to help improve maternity and neonatal outcomes.

Scorecards

A quality improvement tool, essentially an excel document that is produced annually.

It contains 10 years of CNST claims data by clinical incident date.

*Clinical Negligence Scheme for Trust (CNST)



The key data includes:

- Volume and value of claims.
- Speciality.
- Cause codes.
- Injury codes.
- Site & location.
- Status of the claims.
- Incident description.

Using the CNST scorecard

1. **Identify the claims data for maternity & neonatal services from the most recent CNST scorecard.**
   - Ask the Trust legal team for a copy of the 'All data' tab, to include the specialties of Obstetrics, Gynaecology and Neonatology.

2. **Audit the claims within the 'All data' tab**
   - Attain the NHS number, either from the legal team if readily available or use the member reference number / incident date alongside incident description within the 'All data' tab to locate the patient details via the local incident management system.
   - Insert new columns to the 'All data tab' to accommodate local information on the following areas:

NHS number	Postcode	Indices of Deprivation	Ethnicity	MNSI	Early Notification Scheme	PMRT	PSIRF	MOSS

   - Audit the claims against the above areas in relation to the patient care associated with the incident, using local information to consider the deeper learning themes associated with claims.
   - Consider recoding the claims by using the language for coding used locally when identifying themes as this will aid triangulation.

Using claims for thematic reports on learning & actions

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Review the themes or repeated injuries identified within the clinical claims to triangulate against the actions from the reviews outlined within **Safety Action C**
MNSI,
NHSR EN reports,
Local PMRT,
PSIRF reviews,
MOSS critical safety checks

Themes unique to claims → Are there any ongoing risk for future claims?

No common themes between claims & the actions from reviews → Is there an opportunity to recognise improved outcomes from quality improvement or changes in practice?

Common themes found between claims & the actions from reviews →
- Outline the measures planned to address the recurrent themes.
- Note the progress of any ongoing measures.
- Identify any opportunities for shared learning.
- Consider inclusion to MDT Training

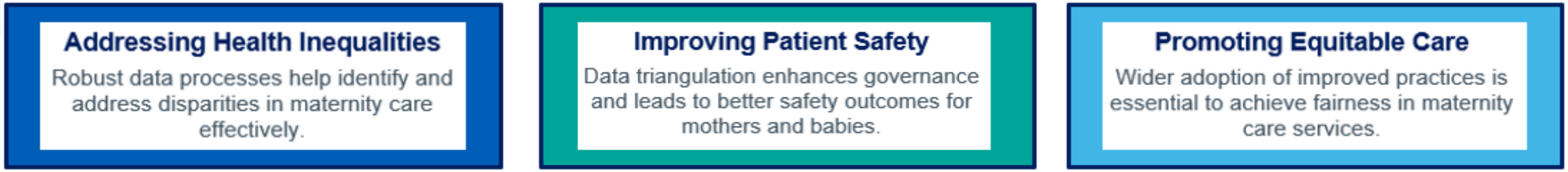
Use demographic data to identify and understand any disparities in outcomes

Key take aways

- NHS Resolution Safety and Learning team can offer support in relation to using the scorecard.

  Email: nhsr.safety@nhs.net

- The triangulation of the learning from claims with the actions from the specified reports can help prioritise quality improvement to help improve maternity and neonatal outcomes.



Contact Safety and Learning

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Advise / Resolve / Learn

What Good Looks Like:

Appropriate Service User Voice Representation and Involvement

Laura Wetherall

National Maternity Service User Voice Representative
NHS Resolution

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Safety Action C **challenges** systems and services to embed the voice, intelligence and insight of people who use services in how they **learn and change**.

Service user voice – meaning families directly, and the intelligence and insight of all families through strategic service user voice representation / MNVP Lead

Service user insight is treated as **core safety intelligence, alongside clinical data**.

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*….the scheme reinforces the importance of **listening to and acting on the voices of women**, families and carers. Their experiences and insights are **essential** to shaping **safe, equitable and compassionate care**, and they remain a core part of the scheme's design and expectations. (p5 MIS Core Standards)*

Perinatal Leadership Team
*Cross specialty **leadership group** …. typically includes (but is not restricted to) the Director of Midwifery, Clinical Directors for Obstetrics and Neonatology, the Lead Nurse for Neonatal Services, the Lead Anaesthetist for Obstetrics, and the **MNVP Lead, who represents the wider service user voice**. (p6. MIS Guidance)*

MNVP Leads are involved across review pathways:

- PMRT discussions around actions and themes
- Local investigation reviews
- Safety and Learning fora where CNST Score Cards are discussed
- Attendance at MNSI Trust Review Meetings
- MOSS Critical Safety Reviews

When this happens meaningfully reviews then routinely identify and draw intelligent links between:

- Communication failures
- Health inequalities inadvertently perpetuated
- Consent issues
- Early warning signs missed by the system and clinical gaze

Trust Review Team

Trust Review Team + Family Voice

Trust Review Team + Family Voice + SUVR / MNVP + External Perspective