

HSIB publishes 'Maternity Investigation Programme: Year in Review 2022/23'

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The Healthcare Safety Investigations Branch (HSIB) has recently published its Maternity Investigation Programme: Year in Review 2022/23. The review highlights that during 2022/23, HSIB completed 702 reports and made more than 1,380 safety recommendations. The top three themes for their safety recommendations were (in order of frequency): clinical assessment, guidance and fetal monitoring.

[Maternity Investigation Programme Year in Review 2022/23](#) →

Browne Jacobson's specialist risk management team have experience of working with [maternity services](#) to improve safety and support maternity quality improvement work. We regularly arrange collaboration events to share learning, provide quality assurance awareness for Boards and deliver training on maternity related topics. Our next maternity [Shared Insights](#) session is on 3 October, where we will be discussing disparities in healthcare and the use of health technology to address this.

A number of investigatory changes will be happening this autumn, with the creation of the Maternity and Newborn Safety Investigations Special Health Authority (MNSI) (hosted by CQC) and the implementation of a new approach to the investigation of patient safety incidents under the Patient Safety Response Framework (PSIRF). Browne Jacobson can provide advice and support to help with this transition and to ensure the implementation of an effective and compassionate patient safety reporting, learning and improvement system, underpinned by openness and transparency, just culture and continuous learning and improvement. We can also help organisations triangulate data from incidents, complaints and claims, carry out thematic reviews and identify areas for improvement.

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