NHS Resolution

The Maternity/Perinatal Incentive Scheme Year six and seven – January 2025

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Who are we?

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Unique characteristics of perinatal services

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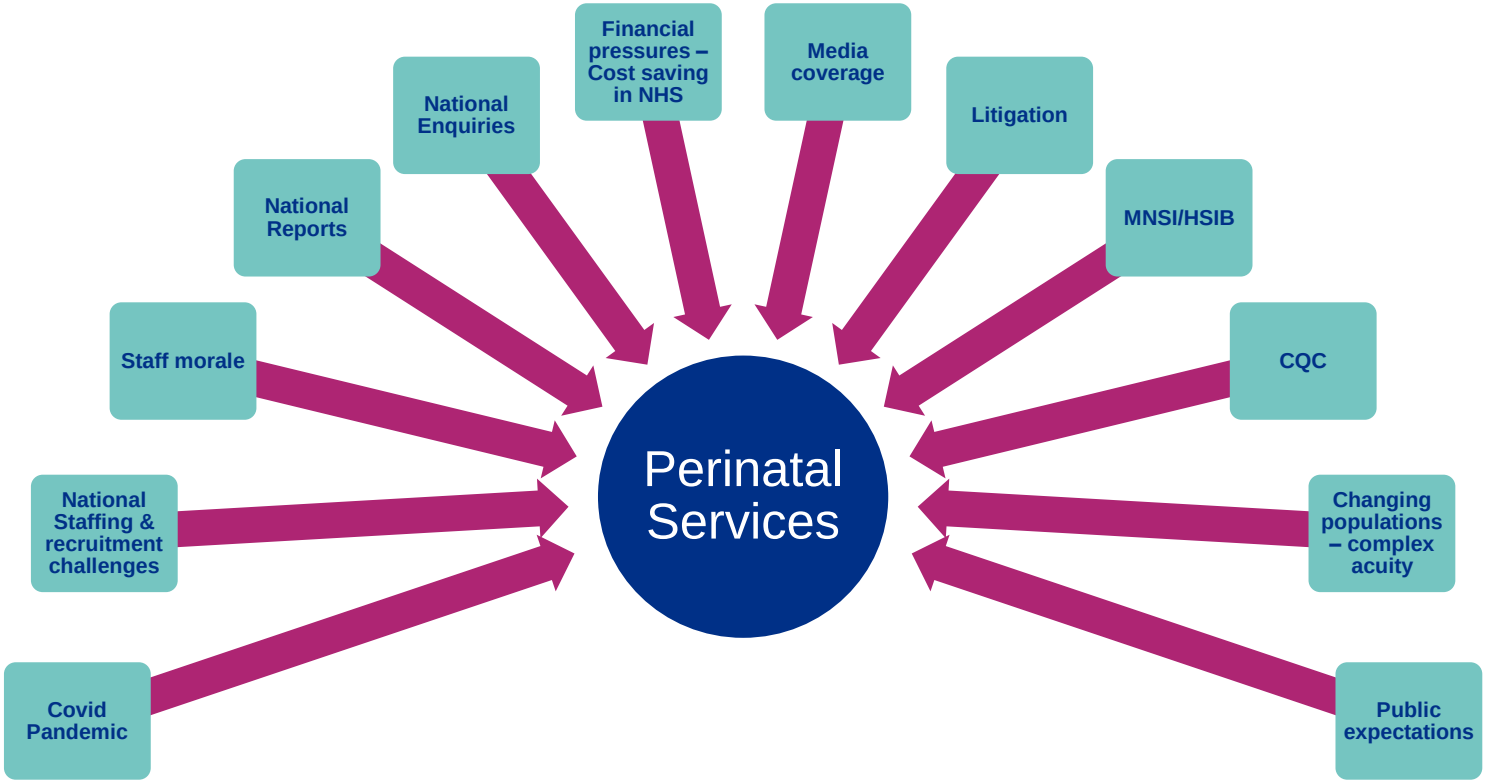
Varied service provision (acute/home/ community care).	Continuous quality improvement – national research and development.	Complex and specialised care. Resource-intensive. 24/7 care.	Whole family involvement. Unique safeguarding and mental health challenges.
Staffing challenges – recruitment and retention.	Unique training requirements - Continuous professional development.	High ‘patient’ volumes. Fluctuating activity. Planning service requirement challenges.	Emotional and sensitive nature.
Enhanced patient experience. Expectations.	Unique opportunity to impact on outcomes for lifetime.	Wide range of inter-disciplinary working with other specialities.	Higher risk and legal implications. Litigation costs.

A system under scrutiny



The bigger picture

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NHS Five Year Forward View
(2014)

Kirkup report
Morecambe Bay
(2015)

National Maternity Safety Ambition
(2015)

Better Births
(2016)

Maternity Transformation Programme
(2016)

Maternity Incentive Scheme Year 1
(2017)

NHS Long Term Plan
(2019)

Ockenden reports
Shrewsbury & Telford
(2020 & 2022)

Reading the Signals
East Kent
(2022)

Health & Care Act – Integrated Care Systems
(2022)

Three Year Delivery Plan
(2023)

Maternity Incentive Scheme Year 6
(2024)

What is the Maternity Incentive Scheme (MIS)?

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National Maternity Safety Ambition (2015) – campaign to reduce maternal deaths, stillbirths, neonatal deaths and brain injuries by half, and reduce preterm births by 2025.

Maternity Incentive Scheme (2017) – NHS Resolution operates the MIS on behalf of Secretary of State for Health and Social Care

Primary objective to reduce the number of maternity claims for neonatal brain injuries & improve patient outcomes.

10 safety actions developed in collaboration designed to support the delivery of best practice in all perinatal services.

Standardised safety actions that all perinatal services are working to meet. Making maternity safety business as usual.

Focus on key areas such as clinical governance, Board oversight, risk management, staff training & patient safety.

Culture of continuous quality improvement, learning from adverse events & when things go well.

Working in collaboration

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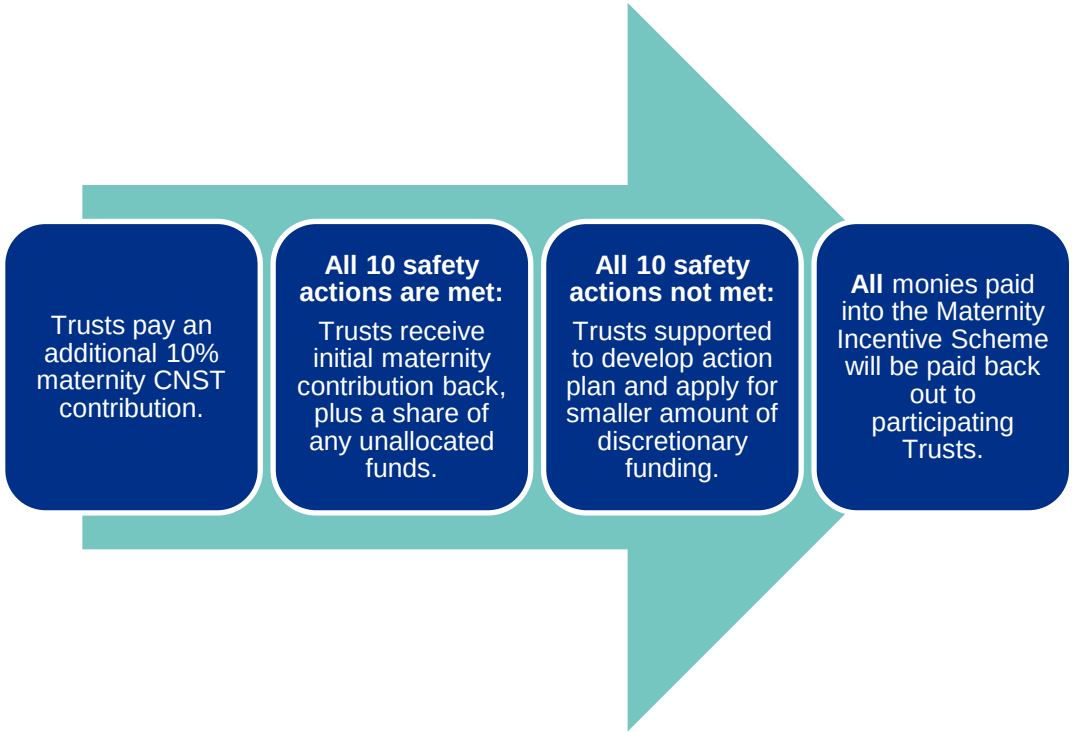
The MIS and each of the safety actions were developed working with the National Maternity Safety Champions and in partnership with the Collaborative Advisory Group which includes senior representatives of the following organisations:

- NHS Digital
- NHS England
- The Royal College of Obstetricians and Gynaecologists
- The Royal College of Midwives
- Royal College of Anaesthetists
- Obstetric Anaesthetists Association
- Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE UK)
- Care Quality Commission
- MNSI
- Service user representatives

The MIS contributes to NHS Resolution Strategic Priority 3 (collaboration to improve maternity services)

How does the MIS operate?



NHS Resolution operates the MIS **on behalf of Secretary of State for Health and Social Care.**

- Trusts self-declare their progress against the 10 safety actions at the end of each year of the scheme.
- Safety actions are evidence based and supported by a safety action lead
- The Trust Board (CEO) and Integrated Care Board (ICB) Accountable Officer must be assured of this progress before signing the Board declaration form.
- Only the declaration form which has been signed off is submitted to NHS Resolution and not the evidence.
- Evidence used to support the position and assure the Board should be retained. In the event that the declaration is later called into question, this evidence may be reviewed by the NHS Resolution Team.

MIS conditions

External verification

Although Trusts self-certify their position, there are also a number of external checks that take place.

- **Safety action 1 - MBRRACE-UK**
- **Safety action 2 - Maternity Services Data Set (MSDS)**
- **Safety action 10 - Early Notification**
- **Safety action 10 - MNSI**
- **CQC sense check**

These findings will override the self-declaration, and may prompt additional scrutiny

Appeals

Trusts have the opportunity to appeal within a 14-day timeframe if they disagree with the final outcome. There are two possible grounds for appeal:

- **Alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation**
- **Technical errors outside the trusts' control and/or caused by NHS Resolution's systems**

Reverification

As part of the MIS conditions, at any time if concerns are raised about a trust or submission, NHS Resolution are required to investigate these. If information that conflicts with their MIS submission is identified, then Trusts may go through a 'reverification' process:

Trusts asked to re-confirm and declare whether they meet all ten safety actions based on evidence sent to their Board at the time of the initial submission.

If their findings do not coincide with the concerns raised, NHS Resolution will ask to review the evidence of their submission.

There will be a request to review previous years' submissions if the outcome of a declaration is changed following this review.

Any maternity incentive scheme contribution and any surplus monies paid to the trust will need to be repaid for non-compliant years.

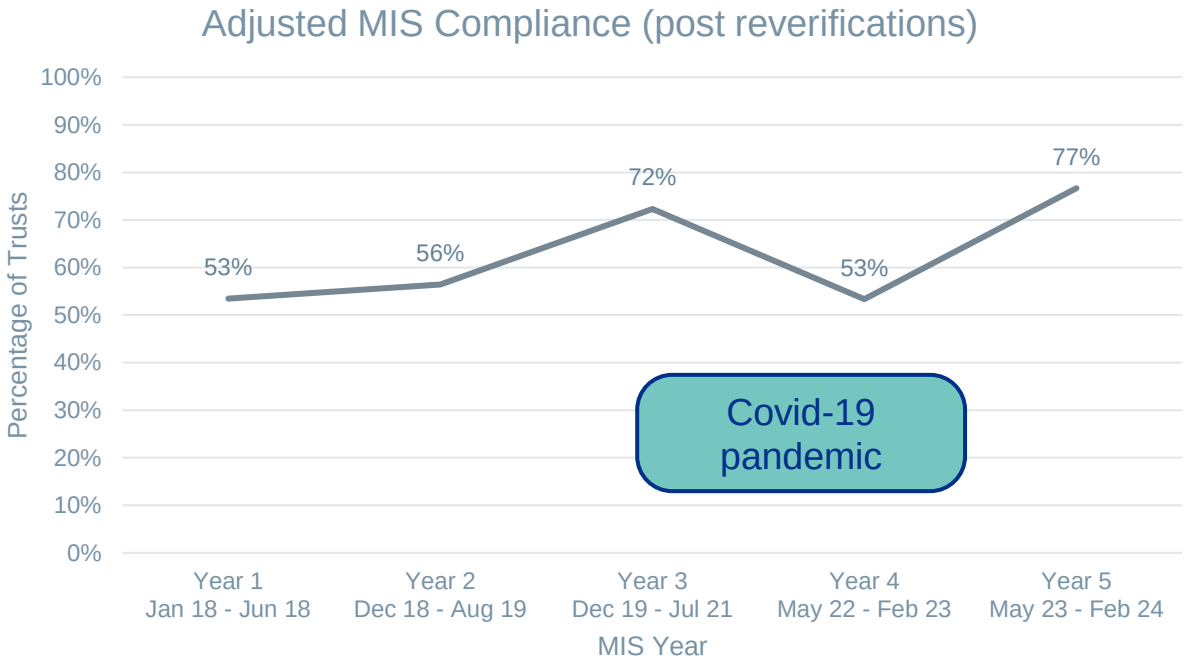
The trust will be given the opportunity to develop an action plan and apply for discretionary funding to support this.

This is a transparent process and is reflected in the published details on the website:

https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

MIS full compliance MIS years* 1-5

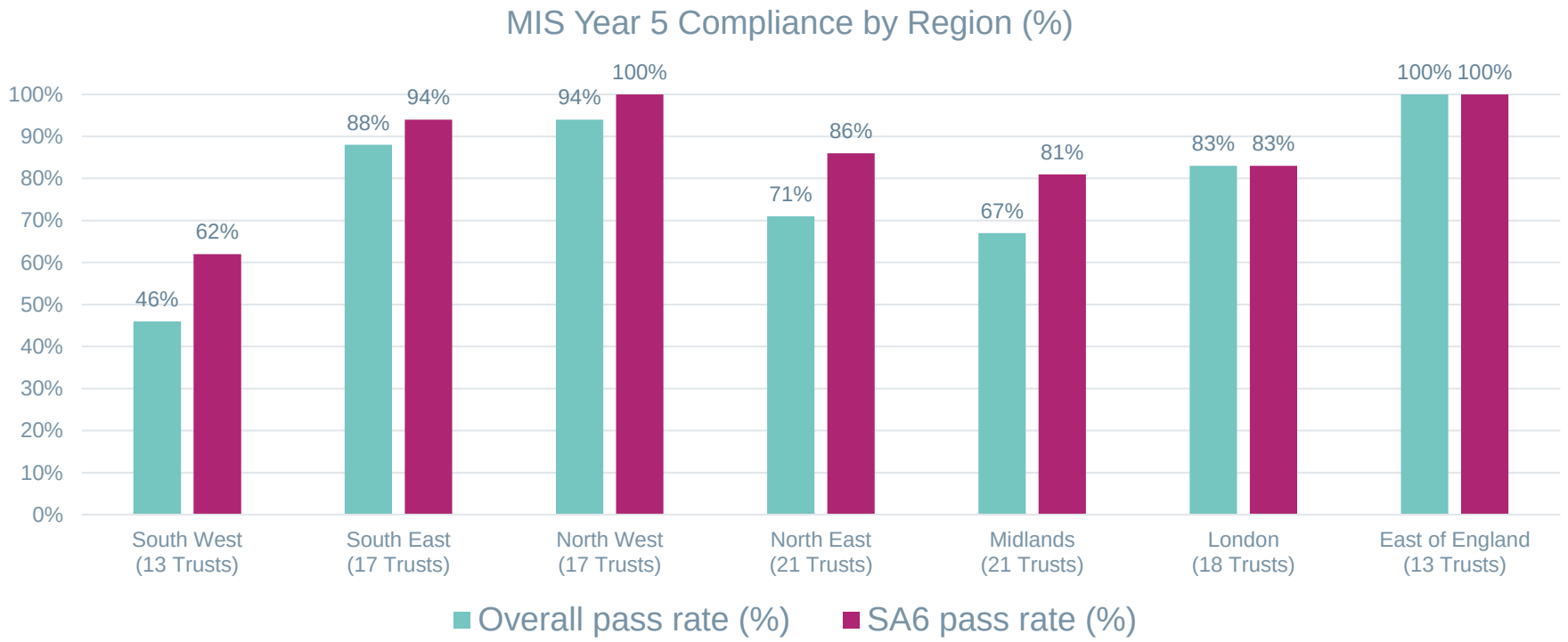
*Although each iteration of the MIS is referred to as a ‘year’, these time periods have varied in response to external factors.



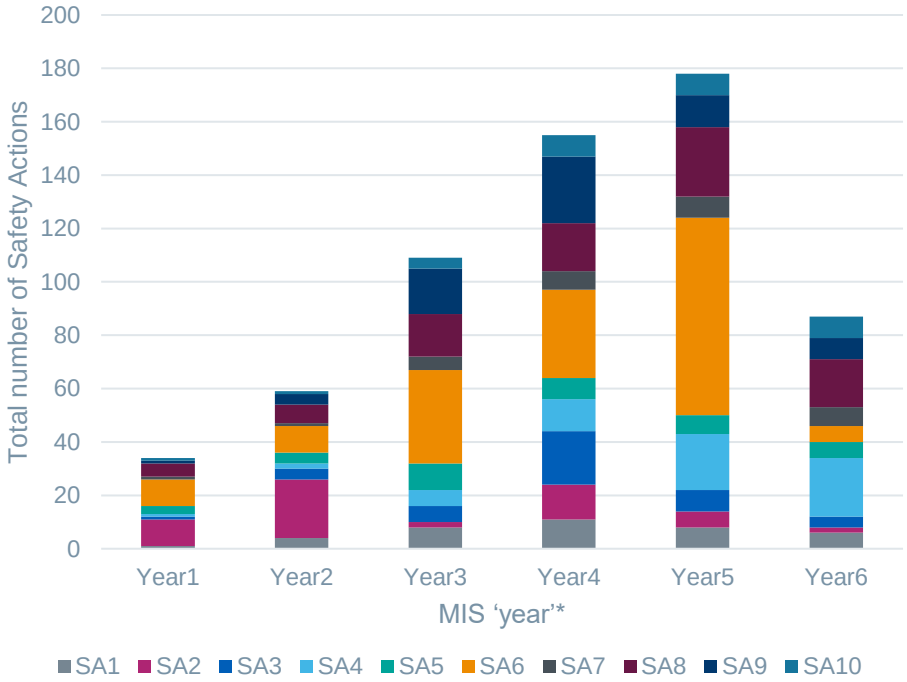
Key considerations

- Covid Pandemic
- Workforce challenges
- Increased discretionary funding in year 4 (for non-compliant Trusts)
- Increased MIS Team and capacity to provide support and communication
- Additional requirement for ICB / LMNS oversight
- Industrial action concessions in year 5
- Improvement in governance / quality of evidence demonstrating compliance
- Regional variation

Year 5 Regional Variation



Year 6 Changes



*Although each iteration of the MIS is referred to as a 'year', these time periods have varied in response to external factors.

In response to system wide challenges, Safety Action Leads were tasked with streamlining the requirements of the MIS for year 6

- All safety actions were to be left in, but the range of asks within each action was to be reduced.
- Requirement to drive improvement, but also reduce the assurance burden on Trusts without compromising the ambition of reducing mortality and brain injury.
- Develop a focus on driving quality improvement.
- Additional measures to support Trusts to be introduced including improved communication, an audit / compliance tool, training/webinars and clearer documentation.
- **Keeping the actions very clear in terms of a yes or no answer to whether someone has done it or not. Shades of grey are not possible to evaluate and can be ambiguous.**

The 10 safety actions

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Safety action 1:
National Perinatal Mortality Review Tool

MBRRACE-UK

Safety action 2:
Data and the Maternity Services Data Set

NHS England

Safety action 3: Transitional care & avoiding term admissions

NHS England

Safety action 4: Clinical workforce planning

RCoA Royal College of Anaesthetists

Royal College of Obstetricians & Gynaecologists

Safety action 5: Midwifery workforce planning

Royal College of Midwives

Safety action 6:
Saving Babies' Lives Care Bundle Version Three

NHS England

Safety action 7:
Listening to women, parents and families & coproduction

NHS England

Safety action 8:
Training

Royal College of Obstetricians & Gynaecologists

NHS England

Safety action 9:
Board assurance on maternity & neonatal safety & quality issues

NHS England

Safety action 10:
Maternity & Newborn Safety Investigations & Early Notification Scheme reporting

MNSI Maternity & Newborn Safety Investigations

NHS Resolution

MIS resources

Overview of progress on safety action requirements

Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	7	0	0	0	7
2	3	0	0	0	3
3	4	0	0	0	4
4	23	0	0	0	23
5	5	0	0	0	5
6	6	0	0	0	6
7	7	0	0	0	7
8	16	0	0	0	16
9	10	0	0	0	10
10	8	0	0	0	8
Total	89	0	0	0	89

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

The MIS document was published with an accompanying audit/compliance tool this year.

- Tool has been designed to support Trusts work towards compliance with the safety actions.
- Not mandatory.
- Developed for internal use only.
- Not intended for submission to NHS Resolution.
- Allows progress tracking with the actions and records when supporting evidence has been approved.

An NHS Resolution FutureNHS launched in April 2024.

- Allows improved communication with members.
- Open and accountable responses to queries.
- Encourages sharing of resources and best practice.
- Support from Maternity Support Programme teams – resources.
- Links to other NHS organisations and information.

[Maternity (and Perinatal) Incentive Scheme - FutureNHS Collaboration Platform]

What does the future look like?

Year seven document in the process of being finalised with Safety Action Leads. This will be externally reviewed with providers.

Year six due for submission by 3 March 2025. Results will be published on website and in a new annual MIS report in April 2025.

Year seven document due for publication 2 April 2025. A summary letter will be sent to all trusts ahead of the publication.

Year seven half-day online launch event w/c 28 April (day to be confirmed). Invites will be sent with all MIS correspondence.

A full **evaluation of MIS** was started in July 2023 and is due for completion and publication in Spring 2025.

How can we help?

NHS Resolution

MIS overview for clinical teams

Recorded webinars & resources on FutureNHS

Individualised advice / linking with action leads

Presentations to Boards

Board reporting workshops / updates

Interactive Board Reporting Workshop

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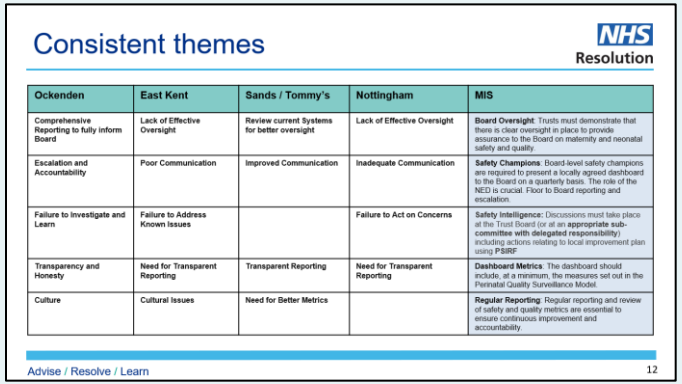

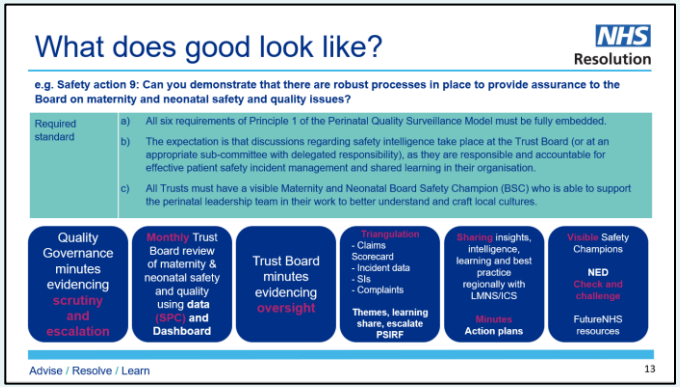

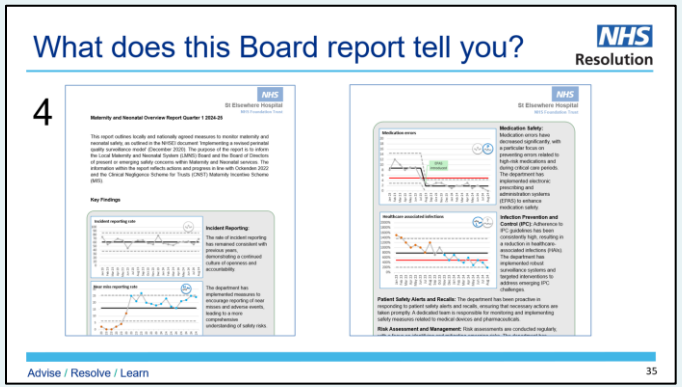

Topics Included

- Perinatal service challenges
- Origins of MIS
- Maternity enquiries
- Themes relating to Board reporting
- What does ‘good’ look like
- Quality Governance Committees
- Scorecards
  - How to access
  - How to interpret
- GIRFT
- Triangulation of safety insights
- Board reporting examples
- Using SPC charts
- Assurance vs. Reassurance
- Evidence examples
- Additional support available from NHSR

Any Questions?

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