Maternity (Perinatal) Incentive Scheme

Year Seven v1.0

Conditions of the scheme

Ten maternity safety actions

Additional guidance

Contents

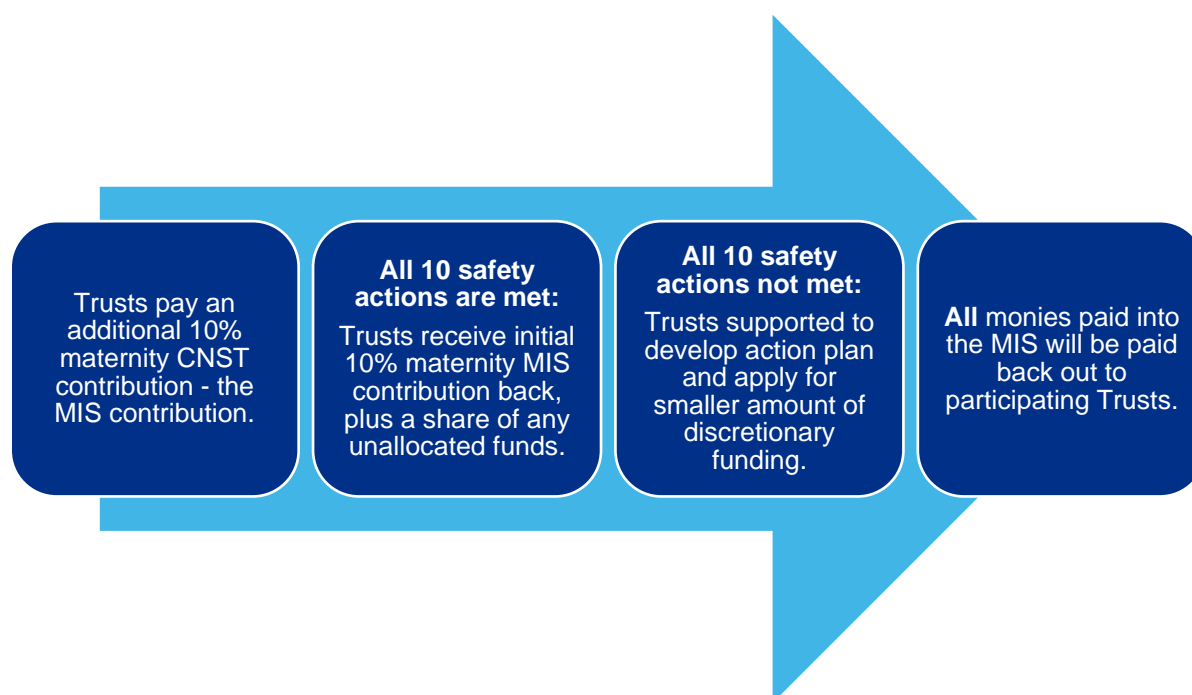**Introduction**

Now in its seventh year of operation, NHS Resolution's Maternity (Perinatal) Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

The MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST). As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST MIS fund:

Trusts pay an additional 10% maternity CNST contribution - the MIS contribution.

All 10 safety actions are met: Trusts receive initial 10% maternity MIS contribution back, plus a share of any unallocated funds.

All 10 safety actions not met: Trusts supported to develop action plan and apply for smaller amount of discretionary funding.

All monies paid into the MIS will be paid back out to participating Trusts.

The original ten safety actions were developed in 2017 and have been updated annually by a Collaborative Advisory Group (CAG) including NHS Resolution, NHS England, Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Royal College of Anaesthetists (RCoA), the Neonatal Clinical Reference Group (CRG), the Care Quality Commission (CQC), the Maternity and Newborn Safety Investigation Programme (MNSI) and service user representatives.

Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover their trust's element of the contribution relating to the CNST MIS fund and this will be returned to the source of the initial CNST payment. They will also receive a share of any unallocated funds.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST MIS fund but may be eligible for a smaller discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a lower level than the 10% contribution to the MIS fund and is

subject to a cap decided annually by NHS Resolution. The balance of unallocated funds will be shared with the trusts who have achieved all ten safety actions.

MIS year seven: conditions

- To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution via nhsr.mis@nhs.net by **12 noon** on **3 March 2026** and must comply with the following conditions:

- Trusts must achieve all ten maternity safety actions.

- The declaration form is submitted to the Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for maternity services.

- The Trust Board must then give their permission to the Chief Executive Officer (CEO) to sign the Board declaration form prior to submission to NHS Resolution. The Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.

- The Trust's CEO must sign to confirm that:

    ☑ The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.

    ☑ There are no reports covering either year 2024/25 or 2025/26 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration from the same time-period (e.g. CQC inspection report, Healthcare Safety Investigation Branch (HSIB)/ MNSI investigation reports etc.). All such reports should be brought to the MIS team's attention before 3 March 2026.

    ☑ Any reports covering an earlier time-period may prompt a review of a previous MIS submission. *If, following a review of a previous MIS submission, it is found that the Trust was non-compliant then the Trust will immediately return to NHS Resolution that year's MIS funds that were awarded, irrespective of it being a prior financial year.*

- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICS) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' updates from Local Maternity and Neonatal System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of MIS.

NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the MIS results. See 'Reverification'.

NHS Resolution will publish the outcomes of the MIS verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

External verification

Trust MIS submissions will be subject to a range of external verification points at the end of the submission period. These include cross checking with:

MBRRACE-UK data (safety action 1 standards a, b and c).

NHS England regarding submission to the Maternity Services Data Set (safety action 2, all criteria).

MNSI will cross-check the **National Neonatal Research Database (NNRD)** and **NHS Resolution** will cross-check the **NHS Resolution database** for qualifying MNSI and EN incidents reportable (safety action 10) and externally verify that standards A and B have been met in the relevant reporting period. In addition, for standards B and C(i) there is a requirement to complete the field on **NHS Resolution's Claims Reporting Wizard (CMS)**, whether families have been advised of NHS Resolution's involvement. Completion of this will also be monitored and externally validated.

Trust submissions will also be sense checked with the **CQC**, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the MIS via the key lines of enquiry.

Trusts found to be non-compliant following this external verification process cannot report full compliance with the MIS for that year.

Evidence for submission

- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided internally in the Trust to support the Trust Board decision only. This will not be reviewed by NHS Resolution unless requested. See 'Reverification'.

- On the Board Declaration form Trusts must declare YES/NO or N/A (where appropriate) against each of the elements within each safety action sub-requirements.

- Only for specific safety action requirements, Trusts will be able to declare N/A (not applicable) against some of the sub requirements.

- The Trust must also declare on the Board declaration form whether there are any external reports which may contradict their MIS submission and that the MIS evidence has been discussed with commissioners.

- In the event that an MIS submission is found to be knowingly false or misleading, NHS Resolution will escalate the matter to the appropriate regulatory and investigative authorities.

- Trusts will need to report compliance with MIS by **12 noon on 3 March 2026** using the Board declaration form, which will be published on the NHS Resolution website in the forthcoming months.

- The Trust declaration form must be signed by the Trust's CEO, on behalf of the Trust Board and by AO of Clinical Commissioning Group/Integrated Care System.

- The Board declaration form will be made available on the MIS webpage during the MIS reporting period.

'What Good Looks Like'

Trusts are reminded to retain all evidence used to support their compliance position. In the event that NHS Resolution are required to review supporting evidence at a later date (as described below) it must be made available as it was presented to support Board assurance at the time of submission.

Timescales and appeals

- Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net prior to 3 March 2026.

- The Board declaration form must be sent to NHS Resolution via nhsr.mis@nhs.net between 17 February 2026 and 3 March 2026 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 3 March 2026.

- Submissions and any comments/corrections received after 12 noon on 3 March 2026 will not be considered.

- The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe.

- 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 Trust's control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate.

- The NHS Resolution MIS clinical team will review all appeals to determine if these fall into either of the two specified grounds for appeal. If the appeal does not relate to the specified grounds, it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC.

- Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered.

- Appeals must be made in writing to NHS Resolution on the agreed template within two weeks of the final notification of results. Information on how to do this will also be communicated to all Trusts when the confirmed MIS results are sent out.

Trusts who have not met all ten safety actions

Trusts that have not achieved all ten safety actions may be eligible for a smaller amount of funding to support progress. To apply for funding, such Trusts must submit a completed action plan together with their completed Board declaration form by 12 noon on 3 March 2026 to NHS Resolution nhsr.mis@nhs.net.

Action plans submitted must be:

- Submitted on the action plan template in the Board declaration form.
- Signed and dated by the Trust CEO.
- Specific to the action(s) not achieved by the Trust.
- SMART (specific, measurable, achievable, realistic and timely) and must enable the financial calculation of the funding requested.
- Detailed regarding banding and Whole Time Equivalent (WTE). Any new roles to be introduced as part of an action plan must include this information.
- Sustainable - Funding is for one year only, so Trusts must demonstrate how future funding will be secured.
- Only submitted for safety actions that have not been achieved.

NHS England Chief Nursing Officer wrote to all NHS Trusts on 8th April 2021 confirming that commissioners must ensure that any funding awarded to implement the agreed action plan for improvement is ringfenced for the maternity service to support the delivery of the action plan.

Reverification

Reverification is initiated if a concern is raised that a Trust Board may have incorrectly declared compliance with one or more of the ten safety actions' sub-requirements within the MIS. This may be identified through whistleblowing or following a CQC report that may call into question the original declaration. This concern may relate to any completed year of the MIS.

In the first instance, Trusts are asked to complete their own internal review of the evidence that was used to support their compliance for the relevant year at the time of submission. This must be the same evidence that was used to inform the Trust Board at the point of declaration. Trusts will be given the opportunity to downgrade their position at this point.

| Trusts asked to **re-confirm** and declare whether they still meet all ten safety actions based on evidence sent to their Board at the time of the initial submission. | If their re-confirmation findings conflict with the concerns raised, NHS Resolution will ask to review all the evidence used for their submission. | There will be a request to review previous years' submissions if the outcome of a declaration is changed following this review. | Any MIS 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. |

If following their own internal review, the Trust remains confident that their compliance declaration was correct, the Trust will be asked to provide all of their supporting evidence to NHS Resolution. A full review of the relevant evidence will then be undertaken by two members of the MIS clinical team.

Following this review, any Trusts found to have mis-declared compliance will be notified and will be required to repay the funds originally awarded to them for that MIS year. They will be asked to develop an action plan to introduce safety improvements and work towards full compliance, and they will be advised to bid for discretionary funding to support this action plan. Any discretionary funds agreed must be spent on the improvements in the agreed plan. Any amount of discretionary funding agreed will be deducted from the total MIS rebate amount repayable to NHS Resolution.

If a mis-declaration has been identified (as above), reverification of the previous MIS year will automatically be initiated. When a further mis-declaration is identified, this process will then be repeated for the previous year. This process will be limited to impact the current MIS year, and the two preceding historical MIS years only. For each year where a mis-declaration is identified, the Trust must return to NHS Resolution the full MIS funds originally rewarded for those years, irrespective that they are previous financial years.

Any funds retrieved from non-compliant Trusts will be redistributed to all Trusts that achieved compliance for the applicable MIS year. This redistribution must take place within the same financial year that NHS Resolution receives the funds.

Need Help?

If you have any queries or concerns regarding any aspect of the MIS, please contact the MIS clinical team on nhsr.mis@nhs.net. There is a FutureNHS MIS workspace where queries can be submitted, and additional information and resources will be provided.

To ensure you receive all correspondence relating to the MIS, please add your name to the MIS contacts list.

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?

Required Standard
a) **Notify all death:** All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. (See technical notes 1 to 5).   b) **Seek parents' views of care**: For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 1 December 2024 onwards. (See technical notes 6 to 8)   c) **Review the death and complete the review:** For deaths of babies who were born and died in your Trust from 1st December 2024 onwards multi-disciplinary reviews using the PMRT should be carried out; 95% of reviews should be started within two months of the death, and a minimum of 75% of multi-disciplinary reviews should be completed and published within six months. For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT. (See technical notes 9 to 18)   d) **Report to the Trust Executive:** Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 1 December 2024. (See technical notes 19 to 20)

Minimum Evidence Requirement for Trust Board
Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see technical notes 2 & 4 regarding the introduction of the NHS Submit a Perinatal Event Notification (SPEN) system in 2025). The PMRT must be used to review the care and reports about individual deaths should be generated via the PMRT.   A report should be received by the Trust Executive Board each quarter that includes details of the deaths reviewed, any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.

Verification process
Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**.

NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications. MBRRACE-UK/PMRT will take the data extract for verification on 3 February 2026. Note that it is essential that the technical notes are consulted to ensure that each standard is fully understood and met, for example, what 'starting a review' means and how this is assessed in the verification process.
Relevant Time period
From 1 December 2024 to 30 November 2025

Link to technical guidance

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Required Standard
This relates to improving the quality and completeness of the submission to the Maternity Services Data Set (MSDS). 1. July 2025 data contains valid birthweight information for at least 80% of babies born in the month. This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405). 2. July 2025 data contains valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (Relevant data tables include MSD001; MSD101).
Minimum Evidence Requirement for Trust Board
The Clinical Negligence Scheme for Trusts: Scorecard in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria.
Verification process
All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**. NHS England will cross-reference self-certification of all criteria against data and provide this information to NHS Resolution.
Relevant Time period
From 2 April 2025 to 30 November 2025

Link to technical guidance

Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?

Required Standard
a) Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 35+6 in alignment with the [BAPM Transitional Care Framework for Practice](#)   **Or**   Be able to evidence progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice and submit this to your Trust and the neonatal Operational Delivery Network (ODN) on behalf of the LMNS Boards.   b) Drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake or continue at least one quality improvement initiative to decrease admissions and/or length of infant/mother separation. Progress on initiatives must be shared with the Safety Champions and LMNS.
Minimum Evidence Requirement for Trust Board
Evidence for standard a) to include: **For units with TC pathways**   • Local policy/pathway of TC admission criteria based on BAPM framework for Transitional Care and meeting a minimum of at least one element of HRG XA04.   **For units working towards TC pathways**   • An action plan signed off by Trust and the neonatal ODN on behalf of the LMNS Board for a move towards the TC pathway based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 6.
Evidence for standard b) to include: 1. By 2 September 2025, register the QI project with local Trust quality/service improvement team.   2. By the end of the reporting period, present an update to the LMNS and Safety Champions regarding development and any progress.   OR   For units continuing a QI project from the previous year, demonstrate progress at 6 months and end of MIS reporting year with updates to LMNS and Safety Champions.
Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**.
Relevant Time period
From 2 April 2025 to 30 November 2025

[Link to technical guidance](#)

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Required Standard

a) Obstetric medical workforce

1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

    a. currently work in their unit on the tier 2 or 3 rota
    <u>or</u>
    b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)
    <u>or</u>
    c. hold a certificate of eligibility (CEL) to undertake short-term locums.

    Please see technical guidance for further details

2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level Safety Champions and LMNS Board.
rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf

3) Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where Consultants and Senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. **While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.**
rcog-guidance-on-compensatory-rest.pdf

4) Trusts should ensure they are compliant with Consultant attendance in person to the clinical situations listed in the RCOG workforce document for a minimum of 80% of applicable situations: 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service roles-responsibilities-consultant-report.pdf

b) Anaesthetic medical workforce

A Duty Anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising Anaesthetic Consultant at all times. Where the Duty Anaesthetist has other

responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)

c) Neonatal medical workforce

The neonatal unit meets the relevant BAPM national standards of medical staffing.

or

the standards are not met but there is an action plan with progress against any previously developed action plans and monitored via a risk register.

Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

d) Neonatal nursing workforce

The neonatal unit meets the BAPM neonatal nursing standards.

or

the standards are not met but there is an action plan with progress against any previously developed action plans and monitored via a risk register.

Any action plans should be shared with the LMNS and Neonatal ODN.

Minimum Evidence Requirement for Trust Board

Obstetric medical workforce

1) Trusts/organisations should demonstrate their compliance through an audit via Medical Human Resources.

   Information on the CEL for short term locums is available here: www.rcog.org.uk/cel

   This page contains all the information about the CEL including a link to the guidance document:
   Guidance on the engagement of short-term locums in maternity care (rcog.org.uk)

   A publicly available list of those doctors who hold a certificate of eligibility of available at https://cel.rcog.org.uk

2) Trusts should ensure they are compliant with the engagement of long-term locums using the monitoring effectiveness tool contained within the RCOG guidance document (P8).

3) Trusts/organisations should be working towards developing standard operating procedures, to assure Boards that Consultants/senior SAS Doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without

adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from Consultants and senior SAS Doctors about their ability to take appropriate compensatory rest in such situations.

NB. All 3 of the documents referenced are all hosted on the RCOG Safe Staffing Hub Safe staffing | RCOG

4) Trusts' positions with the requirement should be shared with the Trust Board, the Board-level Safety Champions as well as LMNS.

Anaesthetic medical workforce

The rota should be used to evidence compliance with ACSA standard 1.7.2.1. This can be a representative month of the rota.

Neonatal medical workforce

The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce.

If the requirements are not met, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. The agreed action plan should be monitored via a risk register.

A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).

Neonatal nursing workforce

The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020).

For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. The agreed action plan should be monitored via a risk register.

A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal ODN.

Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**.
Relevant Time period
From 2 April 2025 to 30 November 2025

Link to technical guidance

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required Standard
a) A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years. If this process has not been completed within three years due to measures outside the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this. b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. c) The Midwifery Coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator **at the start of every shift**) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift. d) All women in active labour receive one-to-one midwifery care. e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the MIS year seven reporting period.

Minimum Evidence Requirement for Trust Board
The midwifery staffing report submitted will comprise evidence to support a, b, c and d progress or achievement. It should include: - A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. - In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. - Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.

- The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.

- Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing.

    o The Midwife to birth ratio.

    o The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.

- Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.

Verification process

Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**.

Relevant Time period

From 2 April 2025 to 30 November 2025

Link to technical guidance

Safety action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Required Standard
Provide assurance to the Trust Board and ICB that you are on track to achieve compliance with all six elements of the current version of SBLCB v3 through quarterly quality improvement discussions with the ICB.

Minimum Evidence Requirement for Trust Board
Trusts should be able to demonstrate that at least two (and up to three) quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust. These discussions should include the following: • Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. • Progress against locally agreed improvement aims. • Evidence of sustained improvement where high levels of reliability have already been achieved. • Regular review of local themes and trends with regard to potential harms in each of the six elements. • Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate. *The Three-Year Delivery Plan for Maternity and Neonatal Services* set out that providers should fully implement Saving Babies Lives Version Three by March 2024. However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory. To support compliance, a national Implementation Tool is available for trusts to use if they wish on <u>the Maternity Transformation Programme's Future NHS platform</u>. If used, the tool can support providers to baseline current practice against SBLCBv3, agree a local improvement trajectory with their ICB, and track progress locally in accordance with that trajectory. Where Trusts are not using the Implementation Tool as evidence of compliance, they should provide a signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB.

Verification process

Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**.

Relevant Time period
From 2 April 2025 to 30 November 2025

Link to technical guidance

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

Required Standard

1. Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (published November 2023) including supporting:

   a) Infrastructure
   b) Strategic influence and decision-making.
   c) Engagement and listening to families.

2. Trusts should ensure an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including joint analysis of free text data, and progress monitored regularly by Safety Champions and LMNS Board.

Minimum Evidence Requirement for Trust Board

1.

a) Evidence of MNVP infrastructure being in place from your LMNS/ICB including all of the following:

- Job descriptions for MNVP team
- Contracts for service or grant agreements
- Budget with allocated funds for IT, comms, engagement, training and administrative support
- Local service user volunteer expenses policy including out of pocket expenses and childcare costs

If the above evidence of an MNVP, commissioned and functioning as per national guidance, is unobtainable, there should be evidence that this has been escalated via the Perinatal Quality Surveillance Model (PQSM) at trust, ICB and regional level.

If evidence for a) cannot be provided, then the escalation route must be followed as stated above.

Evidence requirements for b) and c) are only required if evidence has been provided for a)

b) Terms of Reference and evidence of attendance including minutes/action logs that show the MNVP Lead as a quorate member of trust governance, quality, and

safety meetings at speciality/divisional/directorate level including all of the following:

- Safety Champion meetings
- Maternity quality and safety meetings
- Neonatal quality and safety meetings
- PMRT review meeting
- Patient safety meeting
- Guideline committees

c) Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.

2) Evidence of an action plan coproduced following joint review of the annual CQC Maternity Survey free text data which CQC have confirmed is available to all trusts free of charge.

| **Verification process** |
| Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**. |

| **Relevant Time period** |
| From 2 April 2025 to 30 November 2025 |

Link to technical guidance

Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi-professional training?

Required Standard

90% of attendance in each relevant staff group at:
  1. Fetal monitoring training
  2. Multi-professional maternity emergencies training
  3. Neonatal resuscitation training
 	
See technical guidance for full details of relevant staff groups.
 	
ALL staff working in maternity should attend annual training. A 90% minimum compliance is required for every staff group by the end of the MIS year 7 period (30 November 2025).
 	
For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. A commitment and action plan approved by Trust Board must be formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust.
 	
It is important for units to continue to implement all six core modules of the Core Competency Framework, but this will not be measured in Safety Action 8.

Minimum Evidence Requirement for Trust Board
*See technical guidance for details of training requirements and evidence.
Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**.
Relevant Time period
From 1 December 2024 to 30 November 2025

Link to technical guidance

Safety action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Required Standard

a) All Trust requirements of the Perinatal Quality Surveillance Model (PQSM) must be fully embedded with evidence of Trusts working towards the revised Perinatal Quality Oversight Model (PQOM) when published in 2025.

b) The expectation is that discussions regarding safety intelligence take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation. These discussions must include ongoing monitoring of services and trends, with evidence of reporting/escalation to the LMNS/ODN/ICB/ Local & Regional Learning System meetings.

c) All Trusts must have Maternity and Neonatal Board Safety Champions (BSC) who are actively supporting the perinatal leadership team in their work to better understand and craft local cultures.

Minimum Evidence Requirement for Trust Board

Evidence for point a) and b)

- Evidence that a non-executive director (NED) has been appointed and is working with the BSC to develop collaborative relationships between staff, the frontline Maternity, Neonatal and Obstetric Safety Champions, the Perinatal Leadership Team and the Trust Board to understand, communicate and champion learning, challenges, and best practice.

- Evidence that a review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM at least quarterly. This should be presented by a member of the **Perinatal leadership team** to provide supporting context. In line with the PQSM, this must include a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback and review of the culture survey or equivalent.

- Evidence of collaboration with the LMNS/ODN/ICB lead(s), showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.

- Evidence of ongoing engagement sessions with staff as previous years of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2025.

- Evidence that in addition to the regular Trust Board/sub-committee review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting. Scorecard data is triangulated with other quality and safety metrics to inform targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Board or directorate level quality meeting.

Evidence for point c):

Evidence that the Board Safety Champions are supporting their perinatal leadership team to better understand and craft local cultures, including identifying and escalating safety and quality concerns and offering relevant support where required. This will include:

- Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal Leadership Team and the MNVP lead (where their infrastructure is in, as per safety action 7 place) at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.

- Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.

Verification process
All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**.

Relevant Time period
From 2 April 2025 to 30 November 2025

Link to technical guidance

Advise / Resolve / Learn

Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025

Required Standard

(A) Reporting of all qualifying cases to MNSI from 1 December 2024 to 30 November 2025.

(B) Reporting of all qualifying EN cases to NHS Resolution's EN Scheme from 1 December 2024 until 30 November 2025.

(C) For all qualifying cases which have occurred during the period 1 December 2024 to 30 November 2025, the Trust Board are assured that:

   i.   the family have received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them[1]; and

   ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.

1 https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/

Minimum Evidence Requirement for Trust Board

Trust Board sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.

Trust Board sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible, with a SMART plan to address any challenges for the future.

Trust Board sight of evidence of compliance with the statutory duty of candour.

Verification process

All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**.

There is also an external verification process. MNSI will cross-check the National Neonatal Research Database (NNRD) and NHS Resolution will cross-check the NHS Resolution database for qualifying MNSI and EN incidents reportable from 1 December 2024 until 30 November 2025 and will externally verify that standards A and B have been met in the relevant reporting period.

In addition, for standard B and C(i) there is a requirement to complete the field on NHS Resolution's Claims Reporting Wizard (CMS), whether families have been advised of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.

Relevant Time period

From 1 December 2024 to 30 November 2025

Link to technical guidance

Technical Guidance

Technical Guidance for Safety Action 1
Further guidance and information is available on the PMRT website: Maternity Incentive Scheme FAQs. This includes information about how you can use the downloadable reports from the PMRT case management system to track your notifications, reviews and your progress throughout the year meeting Safety Action 1 standard: www.npeu.ox.ac.uk/pmrt/faqsmis These FAQs are also available on the MBRRACE-UK/PMRT reporting website www.mbrrace.ox.ac.uk

SA 1(a) – Notify all eligible deaths	
1.Which perinatal deaths must be notified to MBRRACE-UK?	Details of which perinatal deaths must be notified to MBRRACE-UK are available at: www.npeu.ox.ac.uk/mbrrace-uk/perinatal-programme
2.Where are perinatal deaths notified?	Notifications of deaths must be made, and surveillance forms completed, using the MBRRACE-UK reporting website. It is planned that the Submit a Perinatal Event Notification (SPEN) system will be released by NHS England in 2025. Once this is released notifications of deaths must be made through SPEN and this information will be passed to MBRRACE-UK. It will still then be necessary for reporters to log into the MBRRACE-UK/PMRT system to provide the surveillance information, update the notification if required and to use the PMRT.
3.Should we notify babies who die at home?	Notification and surveillance information must be provided for babies who died after a home birth where care was provided by your Trust and those babies who die at home having been discharged from your Trust.
4.What is the time limit for notifying a perinatal death?	All perinatal deaths eligible to be reported to MBRRACE-UK, via SPEN when available, must be notified to MBRRACE-UK within seven working days.
5.What are the statutory obligations to notify neonatal deaths?	The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification of neonatal deaths to local Child Death Overview Panels. Neonatal deaths must be notified to Child Death Overview Panels (CDOPs) <u>within two working days of the death</u> (where working days are regarded as Monday to Friday).

	This guidance is available at: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england MBRRACE-UK is now the mechanism for reporting neonatal deaths to the relevant CDOP and the National Child Mortality Database (NCMD). The notification of a neonatal death to MBRRACE-UK <u>will automatically be notified</u> to the local CDOP and the NCMD.
SA 1(b) – Seek parents' view of care	
6.We have informed parents that a local review will take place and they have been asked if they have any feedback or questions about their care. However, this information is recorded in another data system and not the clinical records. What should we do?	In order that parents' feedback, perspectives, and any questions they have can be considered during the review, this information needs to be incorporated as part of the review and entered into the PMRT. So, if this information is held in another data system it needs to be brought to the review meeting, incorporated into the PMRT and considered as part of the review discussion. The importance of parents' feedback and perspectives is highlighted by their inclusion as the first set of questions in the PMRT. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials
7.We have contacted the bereaved parents and they don't wish to have any involvement in the review process. What should we do?	Following the death of their baby, before they leave the hospital, all parents must be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information should be supplemented by written information. The process of parent engagement should be guided by the parents. Not all parents will wish to provide their perspective of the care they received or raise any questions and/or concerns, but all parents should be given the opportunity to do so. Some parents may also change their mind about being involved and, without being intrusive, they should be given more than one opportunity to provide their feedback and raise any questions and/or concerns they may subsequently have about their care. Materials to support parent engagement in the local review process are available on the PMRT website at:

	https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials
8.Parents have not responded to our messages and therefore we are unable to discuss their feedback at the review. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information should be supplemented by written information.

If, for any reason, this does not happen and parents cannot be reached after three phone/email attempts, send parents a letter informing them of the review process and inviting them to be in touch with a key contact, if they wish. In addition, if a cause for concern for the mother's wellbeing was raised during her pregnancy consider contacting her GP/primary carer to reach her. If parents do not wish to input into the review process, ask how they would like findings of the perinatal mortality review report communicated to them.

Consider whether parental feedback could be impacted by communication barriers, such as reading level or their first language not being English. For some parents, it may be necessary to give them the opportunity to provide feedback via a number of different methods.

Materials to support parent engagement in the local review process, including an outline of the role of key contact, are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials
PMRT parent materials have been translated into Welsh and the eleven most common languages spoken other than English. See the notes accompanying the flowchart as well as template letters and ensure engagement with parents is recorded within the parent engagement section of the PMRT. |
| **SA 1(c) – Review the death and complete the review** | |
| **9.Which perinatal deaths must be reviewed to meet safety action one standards?** | The following deaths should be reviewed to meet safety action one standards:

i.   Late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation) |

	ii. Stillbirths (from 24+0 weeks' gestation) iii. Neonatal death from 22 weeks' gestation (or 500g if gestation unknown) up to 28 days after birth While it is possible to use the PMRT to review post neonatal deaths (from 29 days after birth) this is NOT a requirement to meet the safety action one standard.
10. What is meant by "starting" a review using the PMRT?	Starting a review in the PMRT requires the death to be notified to MBRRACE-UK for surveillance purposes, and the PMRT to be used to complete the first review session (which might be the first session of several) for that death. As an absolute minimum all the 'factual' questions in the PMRT must be completed for the review to be regarded as started; it is not sufficient to just open and close the PMRT tool, this does not meet the criterion of having started a review. The factual questions are highlighted within the PMRT with the symbol: **FQ** If the PMRT is completed for the booking and antenatal management questions this will ensure that all the relevant factual questions have been answered.
11. What does "multi-disciplinary reviews" mean?	To be multi-disciplinary the team conducting the review should include at least one and preferably two of each of the professionals involved in the care of pregnant women and their babies. Ideally the team should also include an external member (see below). Bereavement care staff (Midwives and Nurses) should form part of the review team to provide their expertise in reviewing the bereavement and follow-up care, and advocate for the parents. Unless they have been specifically employed to do so, it should <u>not</u> be the responsibility of bereavement care staff to run the reviews, chair the panels nor provide administrative support. A list of the members needed to conduct a multi-disciplinary review is available here: https://www.npeu.ox.ac.uk/pmrt/implementation-support See www.npeu.ox.ac.uk/pmrt/faqsmis for more details about multi-disciplinary review.
12. Who can be an "external panel member"?	External panel member(s) should be relevant senior clinicians who are currently practicing clinically and work in a hospital external to the trust undertaking the review and external to any trust involved in the care at any stage.

	Their role is to be present at the review panel and actively participate in the review to provide a 'fresh pair of eyes', independent and robust view of the care provided. This may involve challenging the care that was provided. They should be from a relevant specialities (you may require more than one dependent on the details of the case) and should be senior enough to provide challenge where appropriate and should actively participate in the discussions about the care. If more than one Trust is involved in the review, because more than one Trust was involved in the care, none of these staff members are 'external' panel members because they do not provide an independent view of the care. They should not be listed as 'external' members in the participant list. Although the MNVP member (see SA7) may not be employed directly by the Trust they should not be regarded as, nor documented as, an 'external' member. They are present to represent the wider parent voice. To ensure that external members of the review panel are identified as such the 'participant' feature in the PMRT system has been modified so that this is clear. See www.npeu.ox.ac.uk/pmrt/faqsmis for more details of how to identify external participants.
13.What should we do if our post-mortem service has a long turn-around time or a Coronial post-mortem is likely to take a long time?	For deaths where a post-mortem (PM) has been requested (hospital or coronial) and is likely to take more than six months for the results to be available, the PMRT team at MBRRACE-UK advise that you should start the review of the death, complete and publish the report using the information you have available. When the PM results come back you should contact the PMRT team at MBRRACE-UK who will re-open the review so that the information from the PM can be included. Should the PM findings change the original review findings then a further review session should be carried out taking into account this new information. If you wait until the PM is available before starting a review you risk missing earlier learning opportunities, especially if the turn-around time is considerably longer than six months. Where the post-mortem turn-around time is quicker, then the information from the post-mortem can be included in the original review. Families should be kept informed throughout.

14. What is review assignment?	Where care has been provided in more than one Trust, ideally the review should involve all Trusts in a joint meeting. However, this is not always possible. A feature available in the PMRT is the ability to assign reviews to another Trust for review of elements of the care if some of the care for the women and/or her baby was provided in another Trust. For example, if the baby died in your Trust but antenatal care was provided in another Trust you can assign the review to the other Trust so that they can review the care that they provided. Following their review, the other Trust reassigns the review back to your Trust. You can then review the subsequent care your Trust provided. This avoids multiple, and potentially conflicting, reports being produced, the outcomes of which can be confusing for parents. Instead, a single report is produced, covering the care provided by all Trusts, which can then be summarised as a whole for parents.
15. How does 'assigning a review' impact on safety action 1, especially on starting a review?	If you need to assign a review to another Trust this may affect the ability to meet some of the deadlines for starting, completing and publishing that review. This will be accounted for in the PMRT verification process.
16. What should we do if we do not have any eligible perinatal deaths to review within the relevant time period?	If you do not have any babies that have died between 1 December 2024 and 30 November 2025 you should partner-up with a Trust with which you have a referral relationship to participate in case reviews. This will ensure that you benefit from the learning that arises from conducting reviews.
17. What deaths should we review outside the relevant time period for the Year 7 MIS?	Trusts should review all eligible deaths using the PMRT as a routine ongoing process, irrespective of the timeframe and verification process. Notification, provision of surveillance information and reviewing should continue beyond the deadline for completing the year 7 MIS requirements.
18. What happens when an MNSI (formerly HSIB) investigation takes place?	It is recognised that for a small number of deaths (term intrapartum stillbirths and early neonatal deaths of babies born at term) investigations will be carried out by MNSI (formerly HSIB). Your local review using the PMRT should be started (to identify any early and immediate learning which needs to be actioned) but not completed until the MNSI report is complete. You should consider inviting the MNSI reviewers to attend these reviews to act as external members of the review team, thereby enabling the

Advise / Resolve / Learn

learning from the MNSI review to be incorporated into the PMRT review.

Depending upon the timing of the MNSI report completion achieving the standards for these babies may therefore be impacted by timeframes beyond the Trust's control. For an individual death you can indicate in the MBRRACE-UK/PMRT case management screen that an MNSI investigation is taking place, and this will be accounted for in the external verification process

SA 1(d) – Report to the Trust Executive Board	
19.Can the PMRT help by providing a quarterly report that can be presented to the Trust Executive Board?	Authorised PMRT users can generate reports for their Trust, summarising the results from completed reviews over a period of time defined by the user. These are available under the 'Your Data' tab in the section entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. These reports can be used as the basis for quarterly Trust Board reports and should be discussed with Trust Maternity Safety Champions.
20.Is the quarterly review of the Trust Executive Board report based on a financial or calendar year?	This can be either a financial or calendar year.

Reports for the Trust Executive Board summarising the results from completed reviews over a period time can be generated within the PMRT, by authorised PMRT users, for a user-defined period of time. These are available under the 'Your Data' tab and the report is entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'.

Note that these reports will only show summaries, issues and action plans for reviews that have been <u>completed and published</u>, therefore the time period selected may need to relate to an earlier period than the current quarter and may lag behind the current quarter by up to six months. |
| **Guidance – technical issues and updates** | |
| **What should we do if we experience technical issues using PMRT?** | All Trusts are reminded to contact their IT department regarding any technical issue in the first instance. If this cannot be resolved, then the issue should be escalated to MBRRACE-UK. This can be done through the 'contact us' facility within the MBRRACE-UK/PMRT system or by emailing us at: mbrrace.support@npeu.ox.ac.uk |

If there are any updates on the PMRT for the MIS, where will they be published?	Any updates on the PMRT or the MBRRACE-UK notification and surveillance in relation to the MIS safety action 1, will be communicated via NHS Resolution email and will also be included in the MBRRACE-UK/PMRT 'message of the day'.

Link to Safety Action 1

Technical Guidance for Safety Action 2	
For criteria 1 how is the measure constructed?	*Numerator*: Number of MSD401 records in the reporting period with a birth date in the reporting period, with a corresponding MSD405 record in the reporting period where a valid birthweight is recorded. *Denominator*: Number of MSD401 records in the reporting period with a birth date in the reporting period.
What counts as valid birthweight recording in the MSD405CareActivityBaby table?	A valid birthweight record requires all three of the following: 1. An appropriate birthweight SNOMED code in the MSD405.ObsCode field (see metadata* for list of codes). 2. The numerical birthweight is recorded in the MSD405.ObsValue field. 3. The relevant unit ('G', 'KG', or 'Kilograms') is recorded in the MSD405.UCUMUnit field. The full metadata for this criteria can be found on the Metadata page in the Clinical Negligence Scheme for Trusts Scorecard
Where can I find out further technical information on the above metrics?	Technical information, including relevant MSDSv2 fields and data thresholds required to pass the above metrics can be accessed on NHS Digital's website In the "Meta Data" file (see 'construction' tabs) available within the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics
Where can I find out more about MSDSv2?	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set
Where should I send any queries?	**On MSDS data** For queries regarding your MSDS data submission, or on how your data is reported in the monthly publication series or on the Maternity Services DashBoard please contact maternity.dq@nhs.net. **For any other queries**, please email nhsr.mis@nhs.net

Link to Safety Action 2

Technical Guidance for Safety Action 3	
What is the definition of transitional care?	Transitional care is not a place but a service [see BAPM guidance](#) and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting. Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.
How can we evidence progress towards a transitional care service?	A current action plan with specified timescales and progress against these should be reviewed by the Trust and the neonatal ODN on behalf of the LMNS Boards before the 30 November 2025.
How do we identify our themes of unplanned term admissions?	All term admissions will be reported through DATIX/LFPSE (as per local implementation of PSIRF) and themes identified through this intelligence. ATAIN proforma reviews are no longer mandated.
Late preterm infants are now included- why?	Some units with an established transitional care service may choose to review reasons late preterm infants (34-36+6) are admitted to the neonatal unit (rather than to a transitional care unit). The focus of QI projects should be to reduce infant/mother separation. Routine review of admissions of late preterm infants is not required for this safety action.
Who should be involved in the quality improvement initiatives?	The team should include members of maternity and neonatal multidisciplinary team including liaising with service user representative (MNVP) and support sourced from Trust quality improvement and service improvement teams if required.
How do we register our quality improvement initiative?	This will vary depending on local Trust policy. In the absence of any Trust policy, evidence of registering the quality improvement initiative, could be documented in the Safety Champion minutes.

What is considered as evidence of an update on the quality improvement initiative?	Evidence should include: 1) a presentation to the LMNS which includes an aim statement, measures, change actions and outcomes. 2) Discussion with Safety Champions and noted in the minutes at least once before the end of the reporting period.
Can we continue the QI project commenced in year 6?	Yes, If the QI project undertaken in year 6 is felt to be progressing this safety action, it can continue to be used as a QI project for year 7. However, this should be discussed and agreed with the LMNS and Safety Champion In this case evidence should include 1. Presentation to the LMNS of progress at 6 months and at the end of the reporting period 2. Discussion with Safety Champions and noted in the minutes at least once before the end of the reporting period.
Where can we find additional guidance regarding this safety action?	https://www.bapm.org/resources/24-neonatal-transitional-care-a-framework-for-practice-2017 https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/ Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf (england.nhs.uk) Framework: Early Postnatal Care of the Moderate-Late Preterm Infant | British Association of Perinatal Medicine (bapm.org) B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf (england.nhs.uk) The Handbook of Quality and Service Improvement Tools: the_handbook_of_quality_and_service_improvement_tools_2010-2.pdf (england.nhs.uk)

Link to Safety Action 3

Technical Guidance for Safety Action 4	
a) Obstetric medical workforce guidance	
How can the Trust monitor adherence with the standard relating to short term locums?	Trusts should establish whether any short-term (2 weeks or less) tier 2/3 locums have been undertaken between February and August 2025. Medical Human Resources (HR) or equivalent should confirm that all such locums met the required criteria.
What should a department do if there is non-compliance i.e. locums employed who do not meet the required criteria?	Trusts should review their approval processes and produce an action plan to ensure future compliance.
Can we self-certify compliance with this element of safety action 4 if locums are employed who do not meet the required criteria?	No. An action plan must be developed to prevent this happening in the future, but Trusts would still need to declare non-compliance with this action.
Where can I find the documents relating to short-term locums?	All related documents are available on the RCOG safe staffing page. Safe staffing | RCOG
How can the Trust monitor adherence with the standard relating to long-term locums?	Trusts should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance for each new long-term locum who starts at the Trust over a 6-month period after February 2025 to 30 November 2025.
What should a department do if there is a lack of compliance demonstrated in the audit tool regarding the support and supervision of long-term locums?	Trusts should review their audits and identify where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and assure the Board this is in place and being addressed.
Can we self-certify compliance with this element of safety action 4 if long-term locums are employed	No.

who are not fully supported/supervised?	
Where can I find the documents relating to long-term locums?	All related documents are available on the RCOG safe staffing page. Safe staffing | RCOG
How can the Trust monitor adherence with the standard relating to Standard operating procedures for Consultants and SAS Doctors taking compensatory rest after non-resident on call?	Trusts should have documentary evidence of standard operating procedures and their implementation. Evidence of implementation/compliance could be demonstrated by obtaining feedback from Consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations.
What should a department do if there is a lack of compliance, either no Standard operating procedure or failure to implement such that senior medical staff are unable to access compensatory rest?	Trusts should have a standard operating procedure document regarding compensatory rest. Trusts should identify any lapses in compliance and where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and have this as evidence that they are working towards compliance.
Can we declare compliance with this element of safety action 4 if we do not have a standard operating procedure or it is not fully implemented?	Yes. However, while this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.
Where can I find the documents relating to compensatory rest for Consultants and SAS Doctors?	All related documents are available on the RCOG safe staffing page. Safe staffing | RCOG
How can the Trust monitor adherence with the standard relating to Consultant attendance out of hours?	Departments can audit Consultant attendance for clinical scenarios or situations mandating their presence in the guidance. Trusts should audit any 3-month period from February 2025 to 30 November 2025 and must be compliant for at least 80% of applicable situations. Departments may also wish to monitor adherence via incident reporting systems.

	Feedback from departmental or other surveys may also be employed for triangulation of compliance.
What should a department do if there is non-compliance with attending mandatory scenarios/situations?	Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.
Can we self-certify compliance with this element of safety action 4 if Consultants have not attended all clinical situations on the mandated list?	Yes, as long as compliance can be demonstrated for 80% of applicable clinical situations as detailed in the RCOG roles and responsibilities of the Consultant providing acute care in obstetrics and gynaecology RCOG workforce document.
Where can I find the roles and responsibilities of the Consultant providing acute care in obstetrics and gynaecology RCOG workforce document?	https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/

For queries regarding this safety action please contact: nhsr.mis@nhs.net (MIS Team) or workforce@rcog.org.uk (RCOG).

b) Anaesthetic medical workforce guidance	
Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1	A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients.

c) Neonatal medical workforce guidance	
Do you meet the BAPM national standards of medical staffing depending on unit designation?	If not, Trust Board should agree an action plan and outline progress against any previously agreed action plans. There should also be an indication as to whether the standards are not met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap) alongside a record of the rota tier affected by the gaps.

	This action plan should be submitted to the LMNS and ODN.
BAPM [BAPM_Service_Quality_Standards_FINAL.pdf (amazonaws.com)](#)	

NICU
Neonatal Intensive Care Unit
	All staffing roles should be limited to neonatal care at all levels, i.e. no cross cover with general paediatrics.
	
	Trusts that have more than one NNU providing IC or HD care should have separate cover at all levels of medical staffing appropriate for each level of unit.
	
	Tier 1
	
	    Rotas should be European Working Time Directive (EWTD) compliant and have a minimum of 8 WTE staff
	
	    Units with more than 7000 deliveries should have more than one Tier 1 medical support
	
	Tier 2
	
	    EWTD compliant rota with a minimum of 8 WTE staff
	
	    NICUs undertaking more than 2500 IC days per annum should augment their Tier 2 medical cover (more than one staff member per shift)
	
	Tier 3
	
	    Minimum of 7 WTE Consultants on the on-call rota with 24/7 availability of a Consultant Neonatologist
	
	    NICUs undertaking more than 2500 IC days per annum should provide two Consultant led teams during normal working hours.
	
	    Neonatal Consultant staff should be available on site in all NICUs for at least 12 hours a day,

	generally expected to include two ward rounds/handovers

For units undertaking more than 4000 IC days per annum, consideration should be given to 24-hour Consultant presence

All NICU Consultants appointed from 2010 should have CCT or equivalent in Neonatal Medicine. |
| **LNU**
Local Neonatal Unit | Where LNUs have a very busy paediatric/neonatal service and/or have neonatal and paediatric services that are a significant distance apart, the above staffing levels should be enhanced. The threshold should be judged and monitored on clinical governance grounds such as the ability consistently to attend paediatric or neonatal emergencies immediately when summoned. Units with more than 7000 deliveries should have more than one Tier 1 medical support.

Tier 1

Rotas should be EWTD compliant and have a minimum of 8 WTE staff who do not cover general paediatrics in addition.

Tier 2

Shared rota with paediatrics as determined by a Trust or Health Board's annual NNU activity, comprising a minimum of 8 WTE staff.

Tier 3

Consultants should have a CCT in paediatrics or CESR in paediatrics or an equivalent overseas neonatal or paediatric qualification and substantial exposure to tertiary neonatal practice at least the equivalent of neonatal SPIN. At least one LNU Tier 3 Consultant should have either a CCT in neonatal medicine or neonatal SPIN module (if this was available during training).

All Consultants covering the service must demonstrate expertise in neonatal care (based |

	on training, experience, CPD and on-going appraisal).
SCU **Special Care Unit**	**Tier 1** Rotas should be EWTD compliant and have a minimum of 8 WTE staff who may additionally cover paediatrics if this does not reduce safety and quality of care delivery. There should be a resident Tier 1 practitioner dedicated to the neonatal service during weekday day-time hours and an immediately available resident Tier 1 practitioner 24/7. **Tier 2** Shared rota with paediatrics comprising a minimum of 8 WTE staff. Tiers 1 and/or 2 may be able to be covered by appropriately skilled nursing staff **Tier 3** A minimum of 7 WTE Consultants on the on-call rota with a minimum of 1 Consultant with a designated lead interest in neonatology. Tier 3 Consultants should have a Certificate of CCT in paediatrics or Certificate of Eligibility for Specialist Registration (CESR) in paediatrics or an equivalent overseas neonatal or paediatric qualification. They must demonstrate knowledge, skills and CPD appropriate for the level of neonatal care through annual appraisal. Minimum of 1 Consultant with a designated lead interest in neonatology, who should have completed a special interest (SPIN) module in Neonatology*. (if this was available during training)
Our Trust do not meet the relevant neonatal medical standards and in view of this an	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.

action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	
When should the review take place?	The review should take place at least once during the MIS year 7 reporting period.
Which risk register should this be on?	This should be locally decided depending on individual provider arrangements to ensure regular progress and monitoring.
Please access the followings for further information on Standards	BAPM_Service_Quality_Standards_FINAL.pdf (amazonaws.com)

d) Neonatal nursing workforce guidance	
Where can we find more information about the requirements for neonatal nursing workforce?	Neonatal Nurse staffing standards are set out in the BAPM Service and Quality Standards (2022) service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk The Neonatal Nursing Workforce Calculator (2020) should be used to calculate cot side care and guidance for this tool is available here: Guidance-for-Neonatal-Nursing-Workforce-Tool.pdf Access to the tool and more information will be available through your Neonatal ODN Education and Workforce Lead Nurse.
Our Trust does not meet the relevant nursing standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.

Link to Safety Action 4

Advise / Resolve / Learn

Technical Guidance for Safety Action 5	
What midwifery red flag events could be included in six monthly staffing report (examples only)? **We recommend that Trusts continue to monitor the red flags as per previous year and include those in the six-monthly report to the Trust Board, however this is currently not within the minimal evidential requirements but more a recommendation based on good practice.**	• Redeployment of staff to other services/sites/wards based on acuity. • Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). • Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). • Delay of more than 30 minutes in providing pain relief. • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour. • Delay of two hours or more between admission for induction and beginning of process. • Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). • Any occasion when one Midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally. Please see the following NICE guidance for further details and definitions: safe-midwifery-staffing-for-maternity-settings-pdf-51040125637
Can the labour ward coordinator be considered to be supernumerary if for example they had to relieve staff for breaks on a shift?	A supernumerary coordinator must be allocated for every shift and must start each shift with protected supernumerary status. It is accepted that there may be short periods when the coordinator is temporarily unavailable due to rapidly changing acuity on the labour ward to ensure safety for women, families and staff in the department. The co-ordinator should exercise professional judgement and escalate, if covering for breaks creates a safety risk to other women on labour ward. As long as there is clear evidence that the local escalation policy has been initiated in these circumstances, and this

	is not a recurrent daily event, Trusts may declare compliance with this standard. If the co-ordinator is regularly required to cover for breaks (more than 2-3 times a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above.
What if we do not have 100% supernumerary status for the labour ward coordinator?	An action plan should be produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved.
What if we do not have 100% compliance for 1:1 care in active labour?	An action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. Completion of the action plan will enable the Trust to declare compliance with this sub-requirement.
What if we have been unable to complete a BirthRate+ review within three years due to measure outside the Trust's control?	If this process was commenced but has not been completed within three years due to measures outside the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this.
What should we do if we disagree with the findings of a BirthRate+ review for our circumstances?	BirthRate+ encourages the use of professional judgement in the final determination of maternity safe staffing levels in line with the safe staffing guideline. Professional judgment on safe staffing numbers / levels is the responsibility of the Director of Midwifery / Head of Midwifery, and any deviation from the findings of the BirthRate+ (or equivalent) should be highlighted and clearly documented in the midwifery staffing oversight report that is shared with Board.

Link to Safety Action 5

Technical Guidance for Safety Action 6	
Where can we find guidance regarding this safety action?	Saving Babies' Lives Care Bundle v3: saving-babies-lives-version-three/ An implementation tool is available for trusts to use if they wish at future.nhs.uk/SavingBabiesLives and includes a technical glossary for all metrics and measures. For any further queries regarding the bundle or tool, please email england.maternitytransformation@nhs.net Any queries related to MSDS issues for this safety action can be sent to NHS Digital mailbox maternity.dq@nhs.net. Some data items are (or will later become available) on the National Maternity Dashboard (Element 1); from NNAP Online (Element 5); and from NPID (Element 6). For any other queries relating to MIS compliance, please email nhsr.mis@nhs.net
Is there a requirement on Trusts to evidence SBLCB process and outcome measures through their data submissions to Maternity Services Data Set?	Trusts should be capturing SBLCB data as far as possible in their Maternity Information Systems/Electronic Patient Records and submitted to the MSDS. Where MSDS does not capture all process and outcome indicators given in the care bundle, this is indicated in the Implementation Tool.
What percentage performance is required to be compliant for a given intervention?	Where element process and outcome measures are listed in the evidence requirement of the SBLCB V3 a performance threshold is recommended. However, LMNS/ICBs are able to agree local performance thresholds with a provider in view of local circumstances, and the agreed local improvement trajectory.
How do we provide evidence for the interventions that have been implemented?	Trusts will need to verify with their LMNS/ICB that they have an implemented service locally.
Will the eLfH modules be updated in line with SBLCBv3?	The SBL e-learning for health modules have all been updated to reflect the changes in version 3. A new module for element 6 has also now been developed and published on the e-learning for health site.

Link to Safety Action 6

Technical Guidance for Safety Action 7	
What is the Maternity and Neonatal Voices Partnership?	An MNVP listens to the experiences of women, birthing people and families, and brings together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care. MNVPs ensure that service user voice is at the heart of decision-making in maternity and neonatal services by being embedded within the leadership of provider Trusts and feeding into the local maternity and neonatal system (LMNS). MNVPs ensure service user voice influences improvements in the safety, quality and experience of maternity and neonatal care.
How do we know our MNVP is in line with guidance?	NHS England have published supporting materials including a case study and FAQ for working in line with the guidance here.
We are unsure about the funding for Maternity and Neonatal Voices Partnerships	It is the responsibility of ICBs to: Commission and fund MNVPs, to cover each Trust within their footprint, reflecting the diversity of the local population in line with the ambition above.
What does evidence of MNVP engagement look like?	Engagement can include lots of different methods as detailed in the MNVP Guidance under the section *Engagement and listening to families*. Evidence for this includes: • 15 Steps for Maternity and Neonatal report • MNVP Annual Report • Engagement reports • Expenses paid to service users • List of organisations engaged • Online surveys and feedback mechanisms • Analysis of surveys by demographics of respondents
Why have we removed the need to show evidence of engagement and strategic influence <u>if</u> MNVP infrastructure is not in place?	To enable meaningful, trauma-informed engagement with women and families and to act on what is heard, it is essential that MNVP infrastructure i.e. an adequately funded, employed, trained and supported MNVP team, is in place first. This change reflects feedback from MNVPs who are not adequately resourced to carry out their expected functions in line with the MNVP Guidance.
Why is escalation required where an MNVP is not commissioned and functioning in line with guidance and	Where an MNVP is not adequately funded by the ICB to carry out its functions, there is a risk that Trusts are not adequately listening and acting on safety concerns raised by women and families. Therefore, the Trust must escalate via PQSM to resolve.

what should this look like?	ICBs are expected to develop an action plan with the Trust in response to the escalation and monitor progress through agreed governance processes and via a risk register.
	Trusts should put mitigating actions in place to listen and coproduce with women and families proportionate to MNVP resourcing available until the MNVP is commissioned in line with guidance.
	MNVPs are required to be commissioned and function in line with the MNVP Guidance by the end of the Three-Year Delivery Plan (March 26) therefore this will be an expectation for all organisations after this time.

Link to Safety Action 7

Technical Guidance for Safety Action 8	
How will the 90% attendance compliance be calculated?	The training requires 90% attendance of relevant staff groups by the end of the 12-month MIS period at: 1. Fetal monitoring training 2. Multi-professional maternity Emergencies training 3. Neonatal resuscitation Training
Which maternity staff should be included for Fetal monitoring and surveillance (in the antenatal and intrapartum period)?	Staff who have an intrapartum obstetric responsibility (including antenatal and triage) must attend the fetal surveillance training. Maternity staff attendees must be 90% compliant for each of the following groups to meet the minimum standards: • Obstetric Consultants and SAS Doctors. • All other Obstetric Doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier Obstetric Doctor). • Midwives (including Midwifery Managers and Matrons, Community Midwives; Birth Centre Midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity Theatre Midwives who also work outside of theatres. Staff who do not need to attend include: • Anaesthetic staff • Maternity Critical Care staff (including Operating Department Practitioners, Anaesthetic Nurse Practitioners, Recovery and High Dependency Unit Nurses providing care on the maternity unit) • MSWs • GP and Foundation Level Trainees
Which maternity staff should be included for Maternity emergencies and multi-professional training?	Maternity staff attendees must include 90% of each of the following groups to meet the minimum standards: • Obstetric Consultants and SAS Doctors. • All other Obstetric Doctors including Obstetric Trainees (ST1-7), Sub Speciality Trainees, Locally Employed Doctors (LED), Foundation Year Doctors and GP Trainees contributing to the obstetric rota. • Midwives (including Midwifery Managers and Matrons), Community Midwives; Birth Centre Midwives (working in co-located and standalone birth centres) and bank/agency Midwives. • Maternity Support Workers and Health Care Assistants (to be included in the maternity skill drills as a minimum). • Obstetric Anaesthetic Consultants and autonomously practising Obstetric Anaesthetic Doctors.

	• All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) who contribute to the obstetric rota. This updated requirement is supported by the RCoA and OAA. • Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however they will not be required to attend to meet MIS year 7 compliance assessment. • Neonatal staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however there will be no formal threshold for attendance required to meet MIS year 7 compliance. At least one emergency scenario/drill should be conducted in a clinical area during the whole MIS reporting period, ensuring attendance from the relevant wider professional team, including theatre staff and neonatal staff. The clinical area can be any area where clinical activity takes place e.g. Delivery Suite, Clinic, A&E, theatre, a ward. This should not be a simulation suite.
Training attendance for agency staff	It is the responsibility of the employing agency to provide training for staff, so these staff will not be included in your MIS declaration. However, it is the responsibility of the Trust to ensure that all agency staff have met minimum training requirements before working in the Trust.
Long-term sickness and maternity leave	Any staff absent from work due to long-term sickness (>28 days) or on maternity / parental leave (28 days) will be unable to work clinically or attend training while absent, so these staff will not be included in your MIS declaration while they are absent from work, and for one month after their return. These staff should be prioritised to attend any outstanding training as soon as possible on their return.
Training attendance for rotational medical staff	It is the gold standard that all staff attend training in the unit that they are currently working in, so that they can benefit from local learning and training alongside their multi-disciplinary colleagues, however it is appreciated that this may be especially challenging for rotational staff. In the following circumstances, evidence from rotating resident doctors having completed their training in another maternity unit will be accepted: • Staff must be on rotation.

	• The training must have taken place in any previous Trust on their rotation during the MIS training reporting 12-month period. • Rotational posts must be shorter than 12 months. This evidence may be a training certificate or correspondence from the previous maternity unit. For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. A commitment and action plan must be approved by Trust Board and formally recorded in Trust Board minutes to ensure every staff member has attended all required training within a maximum 6-month period from their start-date with the Trust (but ideally much sooner).
Does the multidisciplinary obstetric emergency training have to be conducted in the clinical area?	Ideally at least one emergency scenario should be conducted in any clinical area as part of each emergency training day. You should aim to ensure that all staff attending emergency training participate in an emergency scenario that is held in a clinical area, but this will not be measured in year 7 of MIS.
Which staff should be included for neonatal resuscitation training?	The staff listed below are required to attend neonatal resuscitation training within MIS year 7: • Neonatal Consultants/SAS Doctors or Paediatric Consultants/SAS Doctors covering neonatal units. • Neonatal resident Doctors (who attend any births) • Neonatal Nurses (Band 5 and above) • Advanced Neonatal Nurse Practitioner (ANNP) • Midwives (including Midwifery Managers and Matrons), Community Midwives, Birth Centre Midwives (working in co-located and standalone birth centres) and bank/agency Midwives. The staff groups below are not required to attend in-house neonatal resuscitation training within this MIS year: • Staff who have already attended a neonatal resuscitation training course consistent with BAPM basic capability Neonatal Airway Capability or above (including external courses such as NLS) during MIS year 7 • NLS instructors that have taught on a course during MIS year 7

	- All Obstetric and Anaesthetic Doctors (Consultants, SAS, LE Doctors and Anaesthetic Trainees) contributing to the obstetric rota. - Maternity Critical Care staff (including Operating Department Practitioners, Anaesthetic Nurse Practitioners, Recovery and High Dependency Unit Nurses providing care on the maternity unit). - Local policy should determine whether Maternity Support Workers are included in basic neonatal resuscitation dependant on their role within the service. - If Nursery Nurses work within the service, this should also be recognised in your local training needs analysis.
Which members of the team can teach basic neonatal resuscitation?	Registered RC-trained NLS instructors should deliver the in-house neonatal resuscitation training annual updates.
What do we do if we do not have enough instructors who are trained as an NLS instructor?	Your Neonatal Consultants and Advanced Neonatal Practitioners (ANNP) will be qualified to deliver the training. You can also liaise with your LMNS to explore sharing of resources. It is recognised that for smaller hospitals, such as those with Special care units, there may be difficulty in resourcing qualified trainers. These units must provide evidence to their Trust Board that they are seeking mitigation across their LMNS and an action plan to work towards qualified NLS instructor status. As a minimum, training should be delivered by someone who holds a valid NLS certificate. Please see the RCUK website for the latest guidance regarding NLS GIC training

Who should attend additional neonatal resuscitation training (such as NLS)?	*A minimum of 90% of paediatric/neonatal staff **who attend neonatal resuscitations unsupervised** should have been trained and assessed in line with the guidance below.*
	
	In line with The British Association of Perinatal Medicine Neonatal Airway Safety Standard Framework for Practice *(April 2024)*
	
	   *All neonatal staff undertaking responsibilities as an **unsupervised** first attender / primary resuscitator attending any birth must have reached a minimum of 'basic capability' as described in the BAPM Neonatal Airway Capability Framework.*
	   No specific training course is mandated. However, the Resuscitation Council UK Neonatal Life Support (NLS) provider certification includes all skills required

	for Basic capability and most skills required for Standard capability. Staff that attend births **with supervision at all times** will not need to complete this assessment process for the purpose of MIS compliance.
The Core Competencies TNA suggests periods of time for each element of training, e.g. 9 hours for fetal monitoring. Is this a mandated amount of time?	We envisage that the fetal monitoring and obstetric emergencies training will require 1 whole day each. The hours for each element of training can be flexed by the individual Trust in response to their own local learning needs.

Link to Safety Action 8

Technical Guidance for Safety Action 9	
Where can I find additional resources?	NHS England, Perinatal Quality Surveillance Model

PSIRF (Patient Safety Incident Response Framework)

Maternity and Neonatal Safety Champions Toolkit September 2020 (england.nhs.uk)

NHS England » Maternity and Neonatal Safety Improvement Programme

The Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace is a dedicated place for Non-Executive Director and Executive Director maternity and neonatal Board Safety Champions to access the culture and leadership programme, view wider resources and engage with a community of practice to support them in their roles.

The Perinatal Culture and Leadership Programme - Maternity Local Transformation Hub - Maternity (future.nhs.uk) is a dedicated space for NHS England's Perinatal Culture and Leadership Programmes, with resources for senior leaders and their teams to support local safety culture work. |
| *Perinatal Leadership Team* | |
| **Who is the Perinatal Leadership team and are they different to the Quad?** | For the purposes of this safety action, the definition of the Perinatal Leadership Team as described in this document, (also known as the 'Quad') consists of neonatal, obstetric, midwifery and operational leads as a minimum.

We recognise there may be additional maternity and neonatal leaders as designated by the Trust, for example a Neonatal Nurse Lead, Anaesthetic Lead or service user / MNVP who may form part of the Perinatal Leadership Team. |
| *Perinatal Quality Surveillance / Oversight Model* | |
| **What is the expectation around the Perinatal Quality Surveillance Model?** | The Perinatal Quality Surveillance Model (PQSM) must be reviewed and the local governance for sharing intelligence checked, and when needed, updated.

- Describe the local governance processes in place to demonstrate how intelligence is shared from the ward to Board.
- Formalise how Trust-level intelligence will be shared and escalated with the LMNS/ICB/ODN quality group and from there with regional quality groups which will |

Advise / Resolve / Learn

	include the Regional Chief Midwife and Lead Obstetrician. • Review the involvement of service user voice leadership in perinatal quality oversight processes and ensure alignment with PQSM A revised version of the PQSM model, to be known as the Perinatal Quality Oversight Model (PQOM) is due to be published in 25/26. Trusts are expected to work to fully embed the PQSM model and evidence work towards implementation of the revised PQOM.
Reporting to Trust Board	
Why has the frequency of the requirement to report to Board changed to quarterly?	To facilitate meaningful discussion, review of data and action, Trusts will now be required to report to their Board at least quarterly. This change reflects feedback received during the development this safety action. Trust board meeting schedules vary and a requirement to report at every meeting may not allow for meaningful discussion and action. Where Trusts are currently reporting to their board more frequently, there is no requirement to reduce the frequency to quarterly. Trusts are encouraged to determine locally if there is a need to report to the Board more frequently.
What do we need to include in the report presented to Board each quarter?	The report should be locally produced as set out in PQSM appx 1. It should include themes identified in line with PSIRF, and actions being taken to support; SUV feedback; staff feedback from frontline Champions' engagement sessions; minimum staffing in maternity and neonatal services and training compliance. Themes and progress with culture improvement plans following local cultural surveys or equivalent should also be included. This may include the SCORE culture survey, any subsequent local culture surveys or qualitative insight, the NHS staff survey, NHS pulse survey, focus groups or suitable alternative. The report can also include additional measures as agreed by the Trust.
What constitutes a Trust Board, can sub committees be categorised as a Board?	In year 6 the standard was updated to reflect that an appropriate Trust Board sub-committee, chaired by a Trust Board member, can be delegated to undertake the monthly review of perinatal safety intelligence reporting. If a sub-committee of the Board undertakes this work, an exception report or highlight report must still be provided to the Board

	including the minimum data set as outlined in the PQSM, and there should be evidence of discussion in the Board minutes.
Culture Surveys	
What is the expectation for Trusts to undertake culture surveys?	Every maternity and neonatal service across England will have participated in the Perinatal Culture and Leadership Programme between 2022-2025. As part of this programme every service completed work to meaningfully understand the culture of their services. This diagnostic was either a SCORE culture survey or an alternative as agreed with the national NHSE team. Diagnostic insights and plans for improvement were to be shared with the Trust Board to enable an understanding and garner support for the work to promote optimal safety cultures, based on the diagnostic findings. The expectation is that all maternity and neonatal services continue paying attention to local cultures and work with their Patient Safety Collaboratives to do this, including considering appropriate interventions to support culture change. The improvement plan should evolve over time in response to updated data and insight and is not something that will ever be 'completed' as culture is ever evolving.
What if our maternity and neonatal services did not undertake the SCORE culture survey as part of the national programme?	The national offer to undertake a SCORE culture survey was a flexible, opt out offer. If your maternity and neonatal services demonstrated that they were already completing work to meaningfully understand local culture, and therefore opted out of the SCORE survey, the expectation is that the Board receives updates on this alternative work. It is important culture improvement work does not stop after formal participation in the national Perinatal Culture and Leadership Programme. The expectation is Trusts work with their Patient Safety Collaboratives to use other data sources, such as the NHS Staff Survey, Pulse Survey's, or suitable local alternatives to continue evolving local culture improvement plans.
Perinatal Culture and Leadership Programme	
Who is expected to have undertaken the Perinatal Culture and Leadership programme?	Senior perinatal leadership teams from all Trusts that have a maternity and neonatal service in England have undertaken the PCLP. This will be representation from the midwifery, obstetric, neonatal, and operational professional groups, usually consisting of the DoM/HoM, Clinical Lead / CD for obstetrics, Clinical Lead for neonates and the Operational Manager.

Safety Champions	
What is the rationale for the Board level Safety Champion safety action?	It is important to ensure all staff are aware of who their frontline and Board Safety Champions are if concerns are to be actively shared. Sharing of insights and good practice between providers, their LMNS, ODN, ICS and regional quality groups should be optimised. The development of a local pathway which describes these relationships, how sharing of information will take place and names of the relevant leaders, will support this standard to realise its aims. The guidance in the link below will support the development of this pathway. Maternity-and-Neonatal-Safety-Champions-Toolkit--2020.pdf
Do both the NED and Executive BSC and all members of the Perinatal Leadership team have to be present at each meeting?	Ideally the meeting would have both Board Safety Champions (BSC) and at least two members of the Perinatal Leadership Team present. If this is not always possible, it would be appropriate for either the Executive or NED BSC and at least one member of the Perinatal Leadership Team to be present, However, the expectation is that each professional group is represented throughout the year, and that the nominated member attending brings all four voices to the conversation. The MNVP play a vital role in developing maternity and neonatal services. Where the infrastructure is in place, MNVP leads should be embedded within the providers leadership team. As stated in SA7 they should be a quorate member of this meeting, sending a deputy member of their team when required. As per SA7, If evidence of an appropriately funded MNVP is not in place and there are meetings when the MNVP is not consistently represented, this should be escalated to Trust board, ICB quality board and regional perinatal team. If quoracy for the meeting is not achieved, Trust's will need to show evidence of how their board safety champions are hearing the voice of families and using this to inform decision making.
What are the expectations of the NED and Exec Board Safety Champion in relation to their support for the Perinatal Culture and Leadership	As detailed in previous year's MIS guidance, regular engagement between Board Safety Champions and senior perinatal leadership teams provides an opportunity to share safety intelligence, examples of best practice, identified areas of challenge and need for support. The meetings should be conducted in an appreciative way, with the perinatal teams being open and transparent and the Board Safety Champions being curious and supportive.

Programme (PCLP), culture surveys and ongoing support for the Perinatal Leadership teams?	
What should be discussed at the bi-monthly meetings between the Board Safety Champion(s) and the Perinatal Leadership teams?	As a minimum the bi-monthly meetings should include the following content: - Ongoing Learning from the Perinatal Culture and Leadership Development Programme and how they are using this locally. - How they plan to continue being curious about their local culture. This may be in the form of pulse surveys, or team check ins. - Progress with interventions relating to culture improvement work, and any further support required from the Board. - Feedback on the support being provided by the Patient Safety Collaboratives - Discussion of any themes from patient feedback, MNVP and complaints. - Escalation and oversight of any concerns or issues raised by staff and resulting actions - Oversight of compliance and progress with CNST, CQC action plans, Ockenden, Kirkup etc
Do the non-executive and executive maternity and neonatal Board Safety Champion have to register to the dedicated FutureNHS workspace to access the resources available this year?	We encourage all NED and Exec Board Safety Champions to register on the Future NHS Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace. New content and resources are added throughout the year, and we would encourage all BSC's to continue to access the page to benefit from these. You can also reach out to other Board Safety Champions and develop your own community of peer support. However, this will not be a formal requirement in year 7 of the MIS.
We have not continued to undertake feedback	Parts a) and b) of the required standard builds on the previous year requirements of the MIS in building visibility and creating the conditions for staff to meet and establish a relationship with their Board level Safety Champions to raise

sessions with the Board Safety Champion, what should we do?	concerns relating to safety and identify any support required from the Board.
	Evidence of quarterly staff engagement sessions will need to be provided covering this reporting period, it is expected that there will be at least quarterly sessions organised and widely advertised to staff. This may include the sessions being visible in wards and notice boards. Staff should be supported to engage with these sessions as freely as possible and a record of feedback and actions made available to all staff after the session
	Part b) requires that progress with actioning named concerns from staff feedback sessions are visible. This builds on requirements made in year three and four of the MIS and the expectation is that this should have been continued.
We are a Trust with more than one site. Do we need to complete the same frequency of engagement sessions in each site as a Trust on one site?	Yes. The expectation is that the same number of engagement sessions are completed at each individual site on a quarterly basis.
What are the expectations of the Board safety Champions in relation to quality improvement work undertaken by the Maternity and Neonatal Quality Improvement Programme?	The Board safety Champions will be expected to continue their support for continuous quality improvement by working with the designated improvement leads to participate and mobilise improvement via the MatNeo Patient Safety Collaboratives. Trusts will be required to undertake improvement including data collection and testing work aligned to the national priorities.
Scorecards	
Where can I find more information re my Trust's scorecard?	More information regarding your Trust's scorecard can be found here.
Why do we need to review the scorecard	The scorecard is a quality improvement tool that provides insight into claims in support of clinical governance and quality assurance in your organisation. It provides details of

quarterly alongside current complaint and incident data?	all CNST claims, combined with data from the EN scheme and can provide a full picture of maternity related claims in your organisation. The scorecard provides 10 years of claims experience allowing the impact of clinical effectiveness and safety interventions to be assessed over time. It should be reviewed alongside other data sets to provide a fuller picture of safety. It highlights themes occurring in claims which can be addressed through staff education and training. The scorecard provides a number of speciality filtered views allowing quick access to the relevant data for your division/speciality. Where data sharing agreements exist, members may share scorecard data to support learning across partnerships, networks and regions. The safety and learning team at NHS Resolution can support you in accessing and using your scorecard, nhsr.safety@nhs.net . A short video on using your scorecard can be found here Videos (resolution.nhs.uk) (Extranet login required). The GIRFT/NHS Resolution Learning from Litigation Claims can be found here Best-practice-in-claims-learning-FINAL.pdf (gettingitrightfirsttime.co.uk) and includes advice on engaging with NHS Resolution Safety and Learning resources, including the scorecard.
Examples have been requested for the scorecards.	The key to making this exercise meaningful is the triangulation of the data. Categorisation of the historical claims on the scorecard and any action taken, then presenting these alongside current incidents and complaints. This allows identification of potential themes or trends, identification of the impact of any learning, and allows you to act quickly if any historical themes re-emerged. NHS Resolution have developed an example template to share, and this can be accessed via the FutureNHS platform Maternity Incentive Team workspace, or the MIS Team can send a copy out on request. NHS Resolution staff are always happy to talk through this process if it is helpful.

Link to Safety Action 9

Technical Guidance for Safety Action 10	
Where can I find information on MNSI?	Information about MNSI and maternity investigations can be found on the MNSI website https://mnsi.org.uk
Where can I find information on the Early Notification scheme?	Information about the EN scheme can be found on the NHS Resolution website: • EN main page • Trusts page • Families page

What are qualifying incidents that need to be reported to MNSI?	Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories:
	
	(i) when the baby was therapeutically cooled (active cooling only), or
	
	(ii) has been diagnosed with moderate to severe encephalopathy, consisting of altered state of consciousness (lethargy, stupor or coma) and at least one of the following:
	
	     (aa) hypotonia;
	     (bb) abnormal reflexes including oculomotor or pupillary abnormalities;
	     (cc) absent or weak suck;
	     (dd) clinical seizures
	
	Trusts are required to report their qualifying cases to MNSI via the electronic portal. Once MNSI have received the above cases they will triage them and advise which investigations they will be progressing for babies who have clinical or MRI evidence of severe brain injury.
	
	* This definition was updated from 1 October 2023. Please see our website for further information, this does not change the cases referred to MNSI.

What is the definition of labour used by MNSI and EN?	The definition of labour used by MNSI and EN includes: • Any labour diagnosed by a health professional, including the latent phase (start) of labour at less than 4cm cervical dilatation. • When the mother called the maternity unit to report any concerns of being in labour, for example (but not limited to)

	• abdominal pains, contractions, or suspected ruptured membranes (waters breaking). • Induction of labour (when labour is started artificially). • When the baby was thought to be alive following suspected or confirmed pre-labour rupture of membranes.
Current reporting requirements to MNSI and NHS Resolution	Trusts are required to report their qualifying cases to MNSI via their reporting portal. In addition, Trusts are required to notify to NHS Resolution, via the Claims Reporting Wizard of qualifying EN cases once MNSI have confirmed they are progressing an investigation due to clinical or MRI evidence of severe brain injury. The Trust must input the MNSI reference number to confirm the investigation is being undertaken by MNSI (otherwise it is rejected). Trusts must also use the EN report form: EN-Report-Form.pdf. Please select Sangita Bodalia, Head of Early Notification (legal) at NHS Resolution on the Claims Reporting Wizard. Once the MNSI final report has been shared by the Trust, the EN team will triage the case based on the MRI findings and then confirm to the Trust which cases will proceed to a liability investigation. We strongly advise making a note of the Claims Management System (CMS) reference number received once the matter is reported, as this will be confirmation that the case has been successfully reported to NHS Resolution.
Reporting when Submit Perinatal Event Notification (SPEN) is introduced	When the new single reporting system also known as Submit Perinatal Event Notification (SPEN) is implemented (expected sometime in 2025) then Trusts will be required to report eligible cases for MNSI and NHS Resolution via the Submit Perinatal Event Notification (SPEN). Further information will be shared once there is an implementation date for SPEN.
What qualifying EN cases need to be reported to NHS Resolution?	• Trusts are required to report cases to NHS Resolution where MNSI are progressing an investigation i.e. those where there is clinical or MRI evidence of severe brain injury and have a confirmed reference number. • Where a family have declined a MNSI investigation, but have requested an EN investigation, the case should also be reported to NHS Resolution and advised of this reason for reporting. There is more information here: ENS Reporting Guide - December 2023 (for Member Trusts) - NHS Resolution

Cases that do not require to be reported to NHS Resolution	• Cases where families have requested a MNSI investigation where the baby has a normal MRI. • Cases where Trusts have requested a MNSI investigation where the baby has a normal MRI. • Cases that MNSI are not investigating.
What if we are unsure whether a case qualifies for referral to MNSI or NHS Resolution?	If a baby has a clinical or MRI evidence of severe brain injury and the case is being investigated by MNSI because of this, then the case should also be reported to NHS Resolution via the Claims Reporting Wizard along with the MNSI reference number (document the MNSI reference in the "any other comments box").
Who should we contact if we have any queries?	Please contact a member of the Early Notification team to discuss further (nhr.enteam@nhs.net) or MNSI maternity team maternityadmins@mnsi.org.uk.
Candour	Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provides that a health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided. Regulation 20 In accordance with the statutory duty of candour, in all relevant cases, families should be 'advised of what enquiries in relation to the incident the health body believes are appropriate' – 20(3)(a) and details of any enquiries to be undertaken (20)(4)(b). This includes details of enquiries undertaken by MNSI and NHS Resolution. Assistance can be found on NHS Resolution's website, including the guidance 'Saying Sorry' as well as an animation on 'Duty of Candour' Trust Boards should be aware that if a breach of the statutory duty of candour in relation to a qualifying case comes to light which calls the validity of certification into question this may result in a review of the Trust submission and in addition trigger escalation to the CQC.
Will we be penalised for late reporting?	Trusts are strongly encouraged to report all qualifying cases to MNSI as soon as they occur and to NHS Resolution as soon as MNSI have confirmed that they are taking forward an investigation. NHS Resolution recommend that you report within

	14 days, as this enables NHS Resolution to initiate processes in relation to family engagement. Trusts will meet the required standard if they can evidence to the Trust Board that they have reported all qualifying cases to MNSI and where applicable, to NHS Resolution and this is confirmed with data held by NNRD and MNSI and NHS Resolution. Where qualifying cases are not reported within two years from the date of the incident, these cases will no longer be eligible for investigation under the Early Notification scheme. Please inform NHS Resolution EN team if this occurs.
What do you mean by accessible format?	A holistic view of the family needs should be considered. Accessibility can include (but is not limited to) language, easy read, digital versus printed versions
What happens if we are not able to provide accessible information to the family?	We encourage you to explore options to support the provision of accessible information, and onward escalation where needed. MNSI have initial referral cards and family information available in multiple languages. If the language requested is not available MNSI will translate into the language required. These can be provided on request from your maternity investigator by the Trust. The Board report should outline any occurrences where accessible information could not be provided, reasons and a SMART action plan to address any challenges for the future.
If we are unable to provide information in an accessible way, will we fail the safety action?	You will be able to pass the safety action as long as a SMART action plan has been developed to support addressing any challenges for the future.
Are there any resources from MNSI and NHSR that we can use?	NHS Resolution have produced an animation for families which can be accessed here: Early Notification Scheme animation on Vimeo There is also a page on the NHS Resolution website: Support for families or carers - NHS Resolution MNSI have a family page on their website: For families

Link to Safety Action 10

MIS Year 7 FAQ	
What do you mean by Trust Board?	Unless explicitly stated, Trust Board can be interpreted as 'the Trust Board or appropriate sub-committee with delegated authority' as long as these sub-committees provide Trust Board with output following their review and discussion.
Why aren't we reporting everything directly to Trust Boards?	Trust Boards have a broad scope of responsibility, covering all aspects of the Trust's governance, strategy, and finances. They provide strategic direction and oversight, while sub-committees such as the Quality Governance Committee takes a more hands-on role in monitoring quality and safety performance reviewing and scrutinising operational detail. It is vital that the most pertinent information that is conveyed to Trust Boards is clearly recognised and not lost in the operational detail of reporting. A sub-committee's in-depth examination of data, reports, and practices provides the Board with a clear understanding of the Trust's performance on quality and safety, including any immediate priorities or exceptions.
How can I evidence an appropriate sub-committee?	A Board Assurance Framework should highlight the decision-making processes within a Trust and detail those committees with delegated authority from the Board. Individual Terms of Reference from sub-committees should also contain this information. Minutes of sub-committee meetings should demonstrate that the required discussion around MIS standards have taken place, including any output which will be conveyed to the Trust Board. This must be recognised within Trust Board minutes.
What is a Quality Governance Committee, and how does it differ from a Trust Board?	A Quality Governance Committee (QGC) is a committee of the Trust Board responsible for overseeing the Trust's quality and safety governance arrangements. It provides assurance to the Trust Board that the Trust has robust systems in place to identify, assess, and mitigate risks to patient safety. The QGC also reviews the Trust's quality improvement initiatives and provides recommendations to the Trust Board. The information presented to a QGC will be more detailed and specific than the information presented to the Trust Board. They should receive regular updates on the Trust's performance in key quality and safety areas, as well as specific data on individual incidents and concerns. The QGC should also have the opportunity to discuss the Trust's quality improvement plans and provide feedback and recommendations.

	A QGC is appropriate to review evidence around safety actions, provide additional scrutiny **and then report to the Trust Board, delivering a summary and highlighting any exceptions or particular areas of concern.** **It is important to ensure that this process facilitates Trust Board oversight, rather than replaces it.**
Where can I find more information about Board Reporting via Quality Governance Committees?	Effective Board Assurance Committees Quality Governance in the NHS
Does 'Board' refer to the Trust Board or would the Maternity Services Clinical Board suffice for the Board notification form?	Trust Boards must self-certify the Trust's final MIS declaration following consideration of the evidence provided. It is recommended that all executive members e.g. finance directors are included in these discussions. If subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of governance which we will escalate to the appropriate arm's length body/NHS system leader. We escalate these concerns to the CQC for their consideration if any further action is required, and to the NHS England regional director, the Deputy Chief Midwifery Officer, Regional Chief Midwife and Department of Health and Social Care (DHSC) for information. In addition, we now publish information on the NHS Resolution website regarding the verification process, the name of the Trusts involved in the MIS re-verification process as well as information on the outcome of the verification (including the number of safety actions not passed).
Do we need to discuss this with our commissioners?	Yes, the CEO of the Trust will ensure that the AO for their ICB is apprised of the MIS safety action evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the evidence to be submitted to NHS Resolution. The declaration form must be signed by both CEO and the AO of Clinical Commissioning Group/Integrated Care System before submission.

What documents do we need to send to you?	The Board declaration form will need to be sent to NHS Resolution. Ensure the Board declaration form has been approved by the Trust Board, signed by the Trust CEO and AO (ICB). Where relevant, an action plan is completed for each action the Trust has not met.
	Please send only the Board notification form to NHS Resolution. Do not send your evidence or any narrative related to your submission to NHS Resolution unless requested to do so for the purpose of reverification.
	Any other documents you are collating should be used to inform your discussions with the Trust Board. These documents and any other evidence used to assure the Board of your position must be retained. In the event that NHS Resolution are required to review supporting evidence at a later date it must be made available as it was presented to support Board assurance at the time of submission.
Where can I find the Trust reporting template which needs to be signed off by the Board?	The Board declaration Excel form will be published on the NHS Resolution website in 2025 and all Trusts will be notified. It is mandatory that Trusts use the Board declaration Excel form when declaring compliance to NHS Resolution. If the Board declaration form is not returned to NHS Resolution by 12 noon on 3 March 2026, NHS Resolution will treat that as a nil response.
Will you accept late submissions?	We will not accept late submissions. The Board declaration form and any action plan will need to be submitted to us no later than **12 noon on 3 March 2026**. If not returned to NHS Resolution by 12 noon on 3 March 2026, NHS Resolution will treat that as a nil response.
Our Trust has queries, who should we contact?	Any queries prior to the 3 March 2026 must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net
Please can you confirm who outcome letters will be sent to?	The MIS outcome letters will be sent to Trust's nominated MIS leads.
What if Trust contact details have changed?	It's the responsibility of the Trusts to inform NHS Resolution of the most updated MIS link contacts via the link on the NHS Resolution website.

What if my Trust has multiple sites providing maternity services?	Multi-site providers will need to demonstrate the evidential requirements for each individual site. The Board declaration should reflect overall actions met for the whole Trust.
Will there be a process for appeals this year?	Yes, there will be an appeals process. Trusts will be allowed 14 days to appeal the decision following the communication of results.

The AAC will consider any valid appeal received from participating Trusts within the designated appeals window timeframe.

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 which a Trust alleges has adversely affected its CNST rebate.

NHS Resolution clinical advisors will review all appeals to ensure validity, to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds, it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC.

Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered.

Further detail on the appeals window dates will be communicated when final results are confirmed and sent to Trusts. |
| **How does the financial element of the scheme work?** | NHS Resolution introduced the MIS to support the delivery of safer maternity care through the introduction of an incentive element to contributions to the CNST.

NHS trusts that provide maternity services are charged an amount in addition to their CNST maternity contribution for the MIS. Where a trust has successfully demonstrated achievement against the ten safety actions, it will recover its element of MIS contribution that went into the maternity incentive fund, plus a share of any unallocated funds. **This rebate will be returned to the original funding source**. Trusts unable to demonstrate achievement of the ten actions may be able to apply for a lesser sum from the fund to help them achieve any unmet actions. |

| | Where a reverification of a prior year takes place, if the trust is found to have mis-declared compliance it must immediately repay to NHS Resolution the funds originally awarded for that MIS year. This is irrespective of the reverification being conducted in a different financial year. Any funds retrieved from non-compliant trusts will be redistributed to all trusts that achieved compliance for the applicable MIS year. This redistribution will take place within in the same financial year that NHS Resolution receives the returned funds.

As NHS Resolution is not deemed a supplier in this arrangement and the arrangement does not meet the definition of a contract, the monies received from the scheme are considered out of scope of IFRS 15. Instead, they are treated as per IAS 1, in that the receipts of funds are offset against the cost of the scheme.

Since the scheme relaunched for 2022/23 compliance with the ten safety actions was assessed in 2024/25. The contributions to the MIS were collected and distributed against achievement of the actions in the 2024/25 financial year. |
|---|---|
| **If we haven't spent our MIS funds, can we carry them over to the next financial year.** | You will need to adhere to the relevant statutory accounting standards for NHS bodies that this may fall under.

NHS Resolution has no influence over this, and if you need any further guidance on the accounting treatment then we recommend speaking to your regional finance contact at NHS England. |
| **Merging Trusts** | Trusts that will be merging during the year seven reporting period (April 2025 – January 2026) must inform NHS Resolution of this via nhsr.mis@nhs.net so that arrangements can be discussed.

In addition, Trust's Directors of Finance or a member of the finance team must make contact with the NHS Resolution finance team by email at nhsr.contributions@nhs.net as soon as possible to discuss the implications of the changes in the way maternity services are to be provided. This could have an impact on the contributions payable for your Trust in 2025/26 and the reporting of claims and management of claims going forward. |