NHS Resolution

Maternity (Perinatal) Incentive Scheme (MIS) Year 7 Launch Event

28 April 2025

Welcome

Megan Bidder, Director of Safety and Learning (Executive Board Director), NHS Resolution

Megan joined NHS Resolution in October 2023 from the Department of Health and Social Care (DHSC), where as Deputy Director Adult Social Care Policy between 2021-2023 she led a high-profile programme of social care policy improvements, focussed on supporting person centred care at home. Megan has expertise in health policy and cross-system collaboration, with a particular focus on children's health and maternity.

As the Director of Safety and Learning for NHS Resolution, Megan leads on improving safety, reducing harm and learning from claims. She is responsible for the delivery of two key maternity programmes – the Maternity Incentive Scheme and the Early Notification Scheme – as well as sharing claims data and insights as a catalyst for improvement across the entire patient safety landscape.

We're delighted to have you join us for the **MIS Year 7 Launch Event**!

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Time	Session Title	Speaker(s)
09:00	Welcome and Housekeeping	Megan Bidder (NHSR)
09.10	Opening address	Kate Brintworth and Donald Peebles (NHSE)
09.25	Introduction to MIS	Bridget Dack and Selina Dubison (NHSR)
09:55	MIS Year 7 changes overview	Bridget Dack and Selina Dubison (NHSR)
10:05	Safety Action 1 - PMRT	(recorded by Jenny Kurinczuk) Peter Smith and Adele Krusche (MBRRACE)
10.20	Break	
10:30	Safety Action 3 – transitional care	Elizabeth Pilling (NCRG)
10:45	Safety Action 4 – obstetric staffing	Laura Hipple (RCOG)
11:00	Safety Action 6 - SBL	Karen Thirsk, Susie Crowe, Professor Eleanor Scott, Alanna Parker (NHS England)
11:30	Safety Action 7 - MNVP	Alison Talbot and Cathy Brewster (NHS England)
11:45	Break	
11:55	Safety Action 8 - training	Tim Draycott (NHSR)
12:10	Maternity Team Reviews	Caroline Latham-Parker, Neil Armstrong and Victoria Bagot (NHSR)
12:25	Safety Action 10 – EN and MNSI	Sandy Lewis (MNSI) Sangita Bodalia & Annette Anderson (NHSR)
12:55	Event close	Becky Wilson-Crellin (NHSR)
13:00	Close	

Opening address

Kate Brintworth, RM, BSc (Hons) MSc is the Chief Midwifery Officer for NHS England.

Kate has worked strategically across many parts of the maternity system, including as Regional Chief Midwife for London, Head of Maternity Transformation at the Royal College of Midwives, and Head of Maternity Commissioning for East London, leading the delivery of the STP Maternity Plan, East London 'Better Birth' Pioneer Programme and development of the Local Maternity System.
Kate has also been part of national and regional maternity networks, London Local Supervising Authority, national expert reference groups for commissioning, postnatal and continuity of care, and research steering groups for complex programmes of research. She has worked in multiple roles as a midwife including as a community midwife, labour ward co-ordinator and manager. Special interests are: reducing inequalities for both staff and service users, system working, organisation of services to support midwives and service users, coproduction, tariff and women making complex care choices.

Donald Peebles is the National Clinical Director for Maternity for NHS England.

Donald has been a Professor of Maternal Fetal Medicine at University College London since 2008 and was Divisional Clinical Director for Women's Health at UCLH from 2014 to 2020. He is subspecialty accredited in Maternal- Fetal Medicine and works mainly in the area of Fetal medicine with special interests in fetal therapy and neurodevelopment.. In 2019 he was part of a team that won a BMJ Clinical Leadership award for setting up a service to treat fetal spina bifida in utero. In 2013 he was appointed as co clinical Director for the NHS England London Maternity Strategic Clinical Network and since 2020 has been a National Specialty Adviser in Obstetrics working with a multidisciplinary national team to improve Maternity Services in England. In particular he leads an initiative to implement maternal medicine networks across England, improve culture of maternity services and provides obstetric leadership to the Maternity Safety Support Programme.

NHS Resolution

The Maternity (Perinatal) Incentive Scheme Overview

Bridget Dack - Maternity Incentive Scheme Clinical Lead
Selina Dubison - Maternity Incentive Scheme Associate

Who are we?

NHS Resolution

#hello my name is…

Bridget

bridget.dack@nhs.net
020 3862 6463

#hello my name is…

Selina

selina.dubison1@nhs.net
020 3862 6398

Unique characteristics of perinatal services

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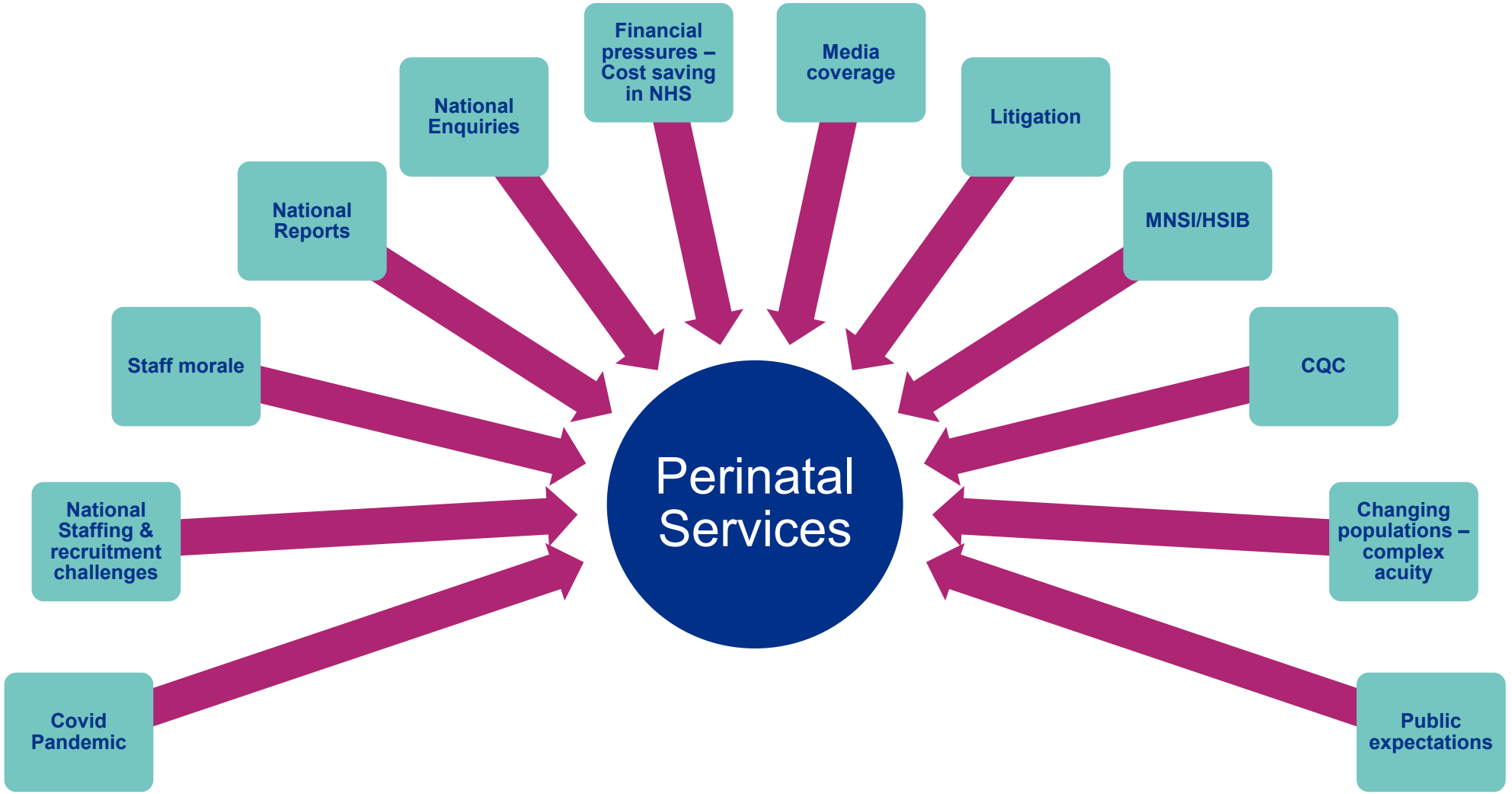
Varied service provision (acute/home/ community care).	Continuous quality improvement – national research and development.	Complex and specialised care. Resource-intensive. 24/7 care.	Whole family involvement. Unique safeguarding and mental health challenges.
Staffing challenges – recruitment and retention.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

A system under scrutiny



The bigger picture

NHS Five Year Forward View
(2014)

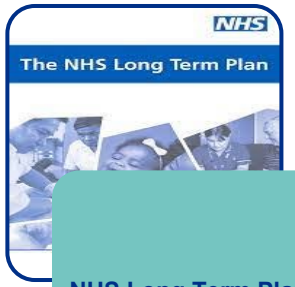
Kirkup report
Morecambe Bay
(2015)

National Maternity Safety Ambition
(2015)

Better Births
(2016)

Maternity Transformation Programme
(2016)

Maternity Incentive Scheme Year 1
(2017)



NHS Long Term Plan
(2019)

Ockenden reports
Shrewsbury & Telford
(2020 & 2022)

Reading the Signals
East Kent
(2022)

Health & Care Act – Integrated Care Systems
(2022)

Three Year Delivery Plan
(2023)

Maternity Incentive Scheme Year 7
(2025)

What is the Maternity (Perinatal) Incentive Scheme (MIS)?

NHS Resolution

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

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

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

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

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

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

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

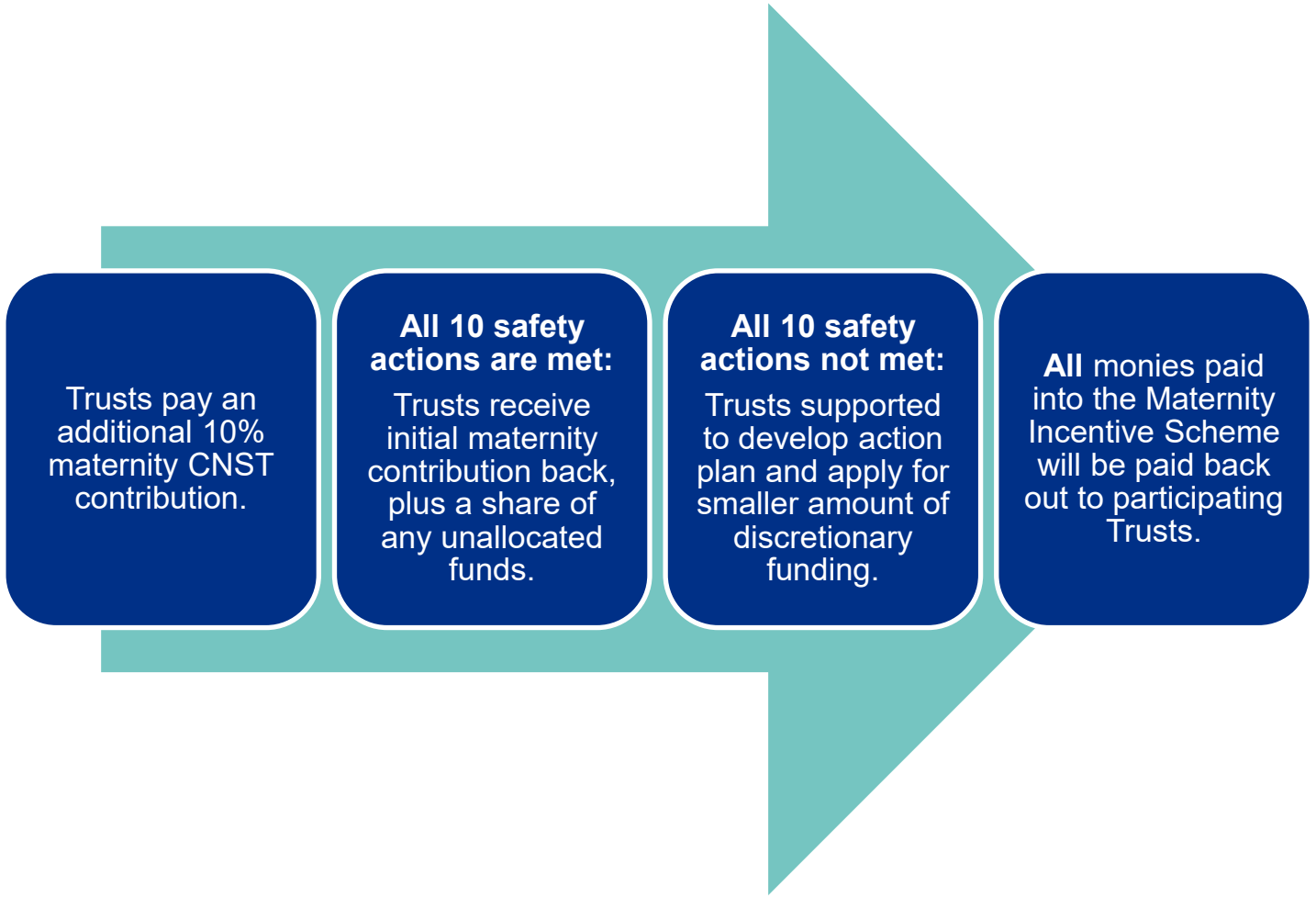
Working in collaboration

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

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

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

How does the MIS operate?



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

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

MIS conditions

External verification

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

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

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

Appeals

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

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

Reverification

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

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

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

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

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

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

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

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

What are the ten safety actions?

NHS Resolution

1. PMRT

All eligible perinatal deaths reviewed using PMRT; parents must be given opportunity to contribute; 50% of reviews must include an external member

2. MSDS

Accurate submission of data (80% valid birthweight and 90% valid ethnicity records)

3. Transitional care

Reduce avoidable separation of mothers and babies, aligned with **BAPM framework**

4. Clinical workforce

Staffing levels, locum policy, and compliance with RCOG & BAPM standards

5. Midwifery workforce

Funded establishment must match evidence-based tools (e.g. BirthRate+); supernumerary coordinator on every shift; 1:1 care in active labour

6. Saving Babies' Lives

Evidence of progress on all six SBLCBv3 elements; QI discussions with ICB

7. Listening to families

Must have a functioning MNVP (as per new 2023 guidance), action plans based on CQC survey

8. Training

90% attendance for all relevant staff at annual fetal monitoring, maternity emergencies, and neonatal resuscitation

9. Board Oversight

Full PQSM implementation; Safety Champion involvement; triangulation of data with complaints, incidents, claims

10. MNSI and EN

100% of qualifying cases reported; families must receive info in accessible formats; duty of candour applied

Why these ten safety actions?

NHS Resolution

1. PMRT

Strong alignment with **Ockenden**, **East Kent**, and **Shrewsbury & Telford**: inquiries cited **missed opportunities to learn from perinatal deaths**, **lack of external scrutiny**, and **poor parental involvement**.

2. MSDS

Inquiries repeatedly noted **poor data quality** and **incomplete ethnicity data**, hindering early identification of disparities.

3. Transitional care

Links to **Ockenden** and emerging findings from **Nottingham** concerns about **unnecessary neonatal admissions**, **poor communication with families**, and **fragmented care**.

4. Clinical workforce

Repeatedly cited across **all inquiries**, most notably **East Kent** and **Shrewsbury**, as core to unsafe care: **shortfalls in obstetric, anaesthetic, and neonatal cover**.

5. Midwifery workforce

A direct response to **Ockenden**, which mandated that Boards fund establishments in line with BirthRate+ and **ensure safe midwifery staffing and oversight.**

Why these ten safety actions?

NHS Resolution

6. Saving Babies' Lives

Multiple inquiries highlight **substandard fetal monitoring**, **poor smoking cessation**, and **missed signs of fetal compromise** – all issues specifically addressed in SBLCBv3.

7. Listening to families

All inquiries highlighted **poor communication and disregard for women's voices**. East Kent in particular highlighted a **systematic dismissal of women's concerns**.

8. Training

Inquiries (emerging findings from **Nottingham** and previously **East Kent**) found training gaps were a key factor in **unsafe care** and **mismanagement of emergencies**.

9. Board Oversight

Directly aligns with inquiry findings on **weak Board engagement**, **poor oversight**, and **lack of triangulated intelligence** (including **Morecambe Bay** and **Ockenden**).

10. MNSI and EN

A critical area across **Shrewsbury**, **East Kent**, and emerging findings from **Nottingham**, where **failure to escalate serious incidents** and **delays in Duty of Candour** caused harm and loss of trust.

How can MIS help?

Raising the Profile of Maternity with Boards

- Provides a structured, nationally recognised framework Boards must engage with
- Elevates maternity safety to a priority issue at executive and non-executive level
- Encourages cross-organisation discussion and collaboration on perinatal safety
- Builds confidence and influence of maternity leaders at Board level

Supporting Effective Business Case Development

- Nationally agreed standards strengthen the case for investment
- Clear expectations help quantify gaps and justify requests
- Can highlight trust-wide governance risks if compliance is at risk
- Useful tool for framing ‘asks’ around safety-critical staffing or infrastructure

Embedding Core Safety Standards

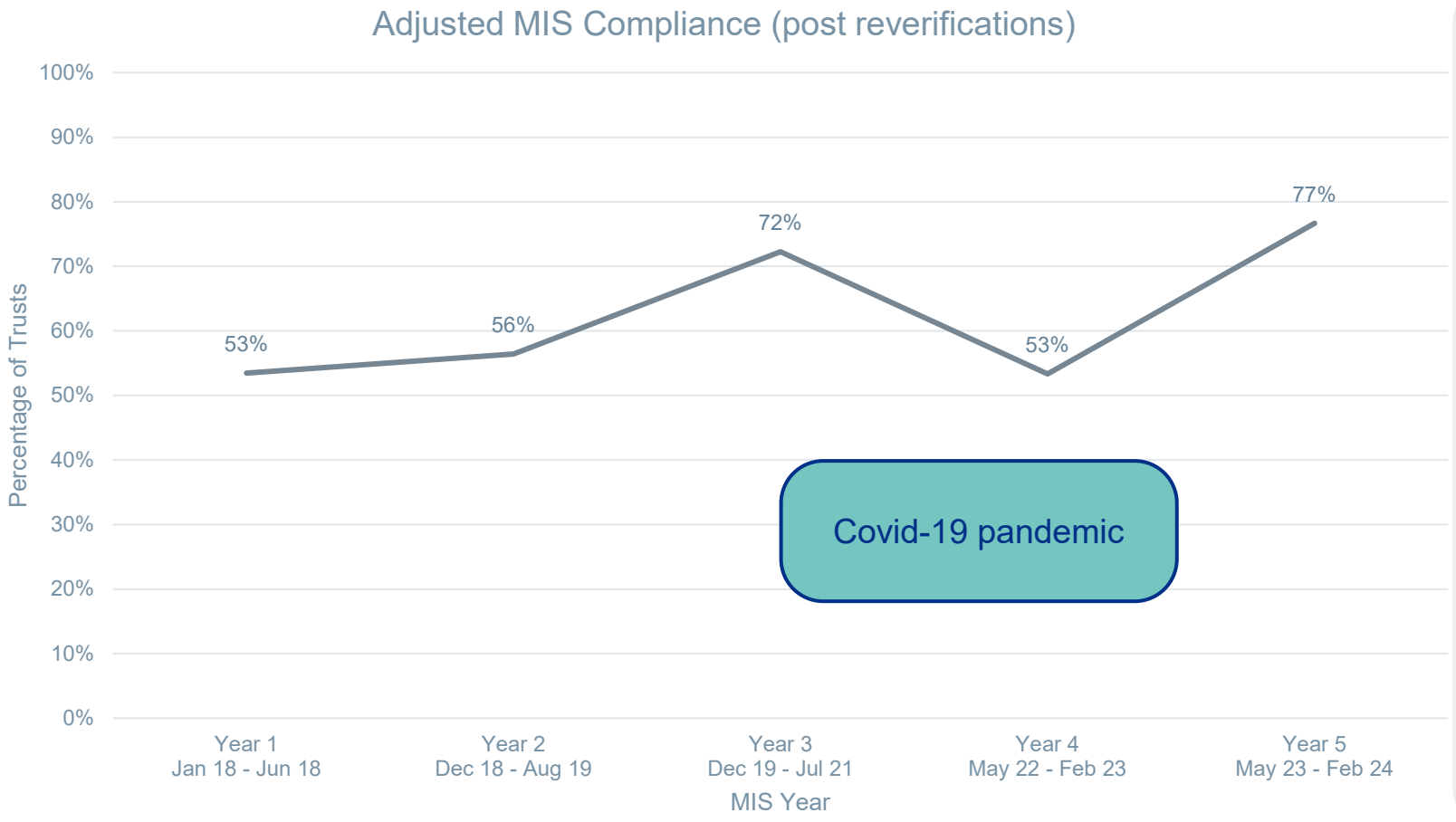
- Aligns local work with national expectations and regulatory frameworks
- Promotes a consistent, equitable standard of care across England
- Strengthens the case for sustained funding in essential safety practices
- Reduces variation and supports benchmarking and peer learning

Driving Continuous Improvement & Governance

- Annual cycle promotes review, reflection, and proactive action
- Encourages meaningful oversight by quality governance committees
- External verification fosters accountability and transparency
- Supports professional development of leaders through strategic engagement

MIS full compliance MIS years* 1-5

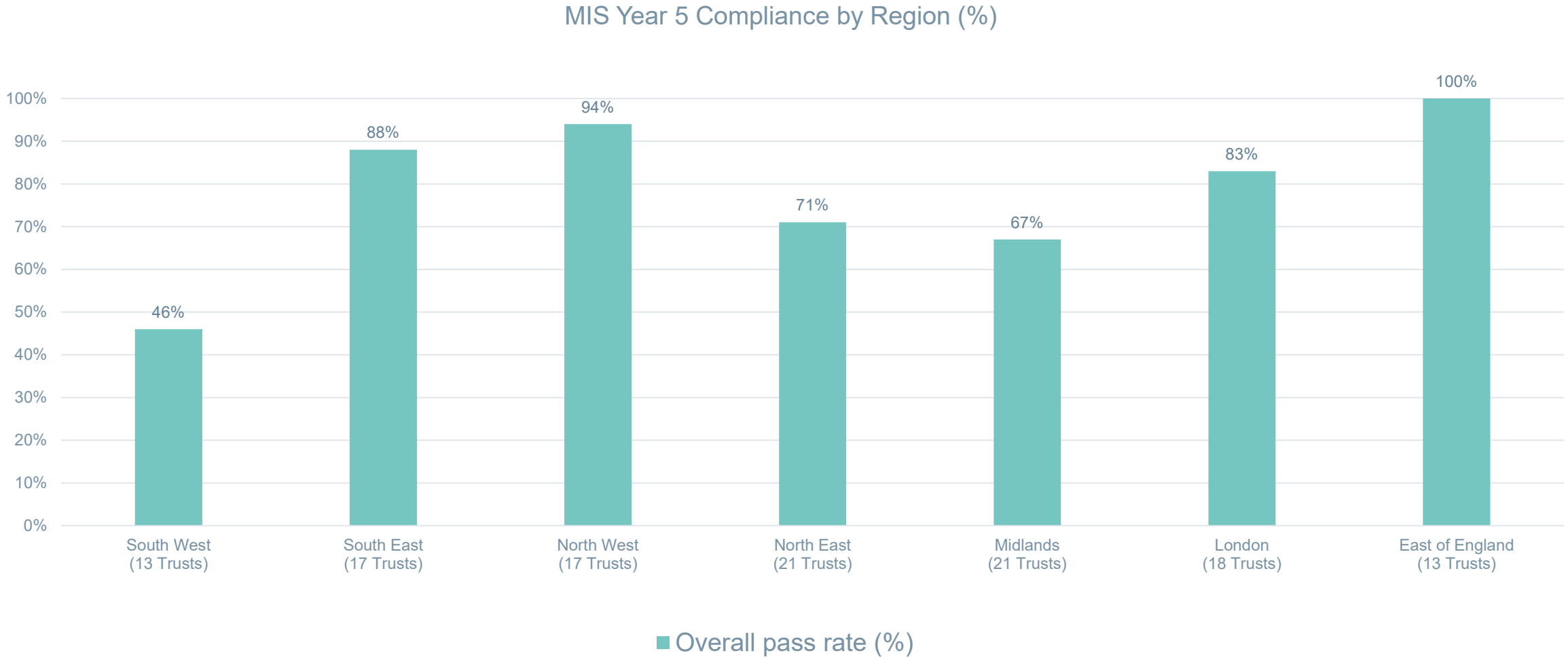
*Although each iteration of the MIS is referred to as a ‘year’, these time periods have varied in response to external factors.



Key considerations

- **Pending publication of Year 6 results (following appeals)**
- Covid Pandemic
- Workforce challenges
- Increased discretionary funding in year 4 (for non-compliant Trusts)
- Increased MIS Team and capacity to provide support and communication
- Additional requirement for ICB / LMNS oversight
- Industrial action concessions in year 5
- Improvement in governance / quality of evidence demonstrating compliance
- Regional variation

Year 5 Regional Variation



MIS resources

Overview of progress on safety action requirements

Safety Action Requirements:

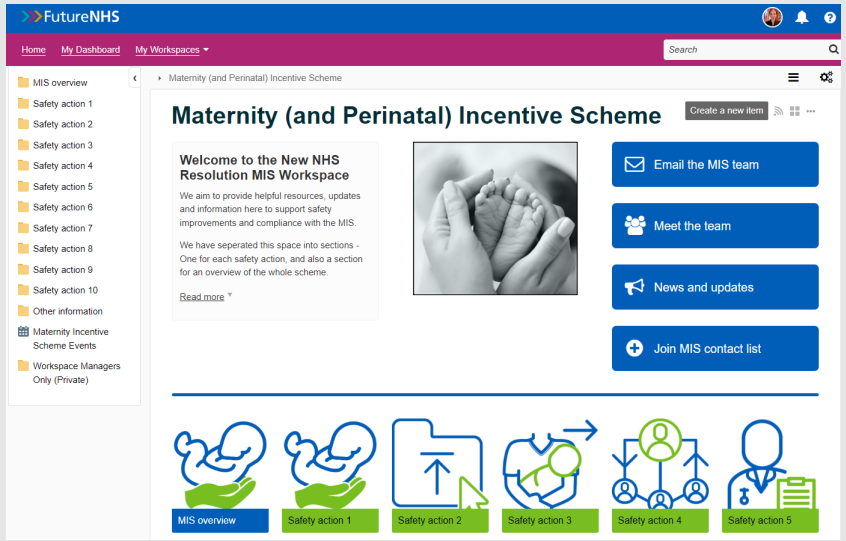
Safety Action	Red	Amber	Green	Blue	Total Requirements
1	7	0	0	0	7
2	3	0	0	0	3
3	4	0	0	0	4
4	23	0	0	0	23
5	5	0	0	0	5
6	6	0	0	0	6
7	7	0	0	0	7
8	16	0	0	0	16
9	10	0	0	0	10
10	8	0	0	0	8
Total	89	0	0	0	89

Key:

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

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

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



An NHS Resolution FutureNHS launched in April 2024.

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

Maternity (and Perinatal) Incentive Scheme - FutureNHS Collaboration Platform

What does the future look like?

Year seven document was published on 2 April 2025. Agreed with our Collaborative Advisory Group & externally reviewed with providers & ICBs.

The 14 day Appeals window is closed. This follows the external verification process.

Year six results will be published on website and in a new annual MIS report in May 2025 pending appeal outcomes.

Year seven due for submission in March 2026.

Publication of findings of **MIS external evaluation** (THIS Institute) due 2025**.**

How can we help?

NHS Resolution

MIS overview for clinical teams

Recorded webinars & resources on FutureNHS

Individualised advice / linking with action leads

Presentations to Boards

Board reporting & business case workshops

Interactive Board Reporting Workshop

NHS Resolution

Nottingham Maternity Review (ongoing)

Lack of Effective Oversight: The review found that there was insufficient oversight from the Trust Board regarding maternity services, leading to gaps in safety and quality assurance.

Inadequate Communication: There were issues with communication between the maternity unit and the Trust Board, resulting in critical information not being effectively relayed.

Failure to Act on Concerns: The review noted that concerns raised by staff and patients were not adequately addressed by the Board, leading to repeated issues.

Need for Transparent Reporting: The review emphasised the importance of transparent and regular reporting to the Board to ensure accountability and continuous improvement.

Advise / Resolve / Learn 11

Consistent themes

Ockenden	East Kent	Sands / Tommy's	Nottingham	MIS
Comprehensive Reporting to fully inform Board	Lack of Effective Oversight	Review current Systems for better oversight	Lack of Effective Oversight	**Board Oversight**: Trusts must demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal safety and quality.
Escalation and Accountability	Poor Communication	Improved Communication	Inadequate Communication	**Safety Champions**: Board-level safety champions are required to present a locally agreed dashboard to the Board on a quarterly basis. The role of the NED is crucial. Floor to Board reporting and escalation.
Failure to Investigate and Learn	Failure to Address Known Issues		Failure to Act on Concerns	**Safety Intelligence:** Discussions must take place at the Trust Board (or at an **appropriate sub-committee with delegated responsibility**) including actions relating to local improvement plan using **PSIRF**
Transparency and Honesty	Need for Transparent Reporting	Transparent Reporting	Need for Transparent Reporting	**Dashboard Metrics**: The dashboard should include, at a minimum, the measures set out in the Perinatal Quality Surveillance Model.
Culture	Cultural Issues	Need for Better Metrics		**Regular Reporting**: Regular reporting and review of safety and quality metrics are essential to ensure continuous improvement and accountability.

Advise / Resolve / Learn 12

What does good look like?

e.g. Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Required standard	a) All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded. 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. c) All Trusts must have a visible Maternity and Neonatal Board Safety Champion (BSC) who is able to support the perinatal leadership team in their work to better understand and craft local cultures.

- Quality Governance minutes evidencing **scrutiny and escalation**
- **Monthly** Trust Board review of maternity & neonatal safety and quality using **data (SPC) and Dashboard**
- Trust Board minutes evidencing **oversight**
- **Triangulation**
  - Claims
  - Scorecard
  - Incident data
  - SIs
  - Complaints

  Themes, learning share, escalate PSIRF
- **Sharing** insights, intelligence, learning and best practice regionally with LMNS/ICS

  Minutes Action plans
- **Visible** Safety Champions

  NED Check and challenge

  FutureNHS resources

Advise / Resolve / Learn 13

What does this Board report tell you?

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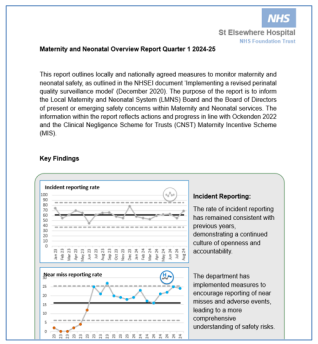

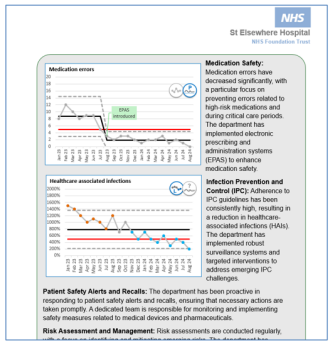

Advise / Resolve / Learn 35

Topics Included

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

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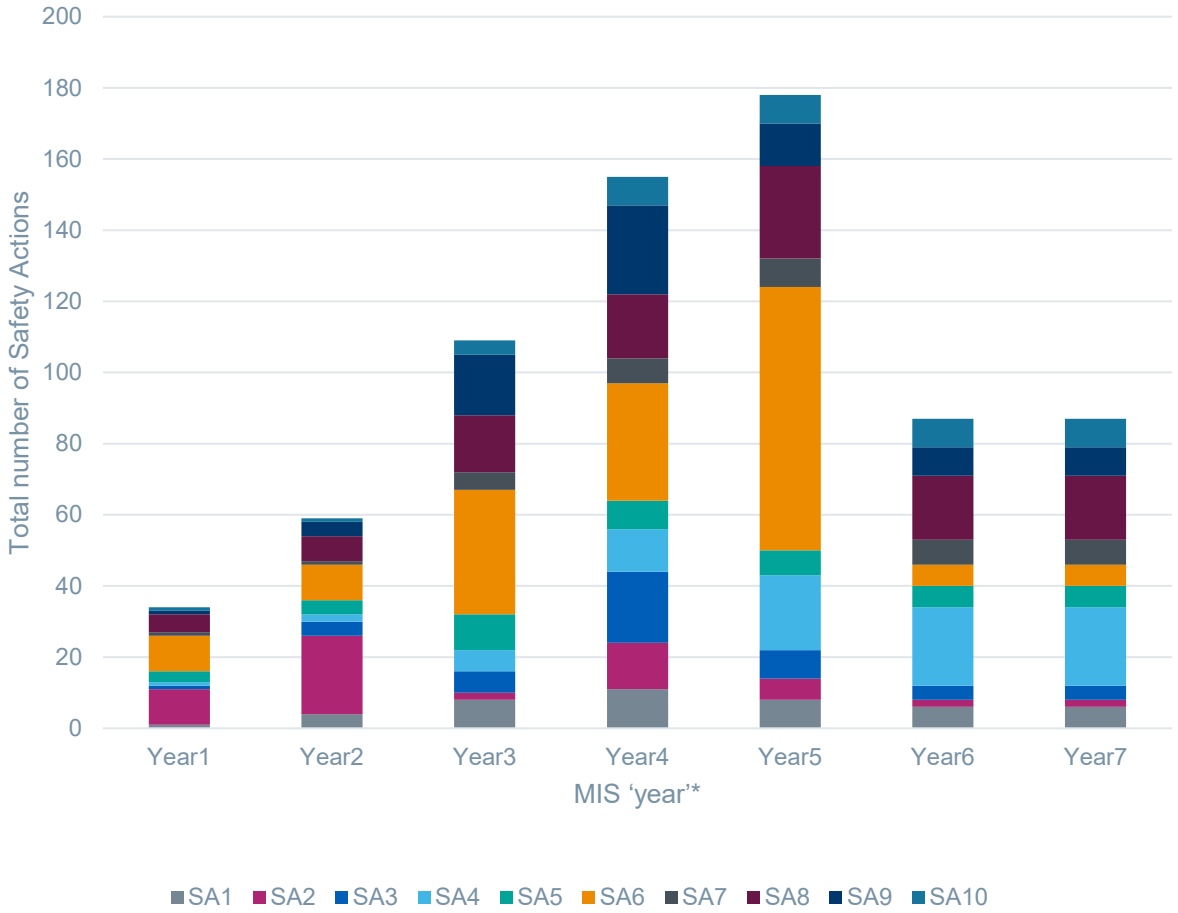
The Maternity (Perinatal) Incentive Scheme Year 7 changes

Bridget Dack - Maternity Incentive Scheme Clinical Lead
Selina Dubison - Maternity Incentive Scheme Associate

Year 7 Changes



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

In response to system wide challenges, Safety Action Leads were tasked with continuing the streamlining approach for MIS year 7

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

MIS year 7 summary of changes

NHS Resolution

 SA1	• Inclusion of external members in PMRT reviews. • 75% reviews to be completed in 6 months
 SA2	• Removal of previous CQIM metrics. • Addition of valid birthweight data for 80% babies in given month as a minimum.
 SA3	• Option to continue previous or start new QI project to reduce admissions. • TC care focus on babies 34+ to 35+6.
 SA4	• 80% compliance with RCOG Consultant attendance over 3-month period. • Neonatal staffing - added to risk register.
 SA5	• Birthrate+ - Professional judgement of DOM/HOM

 SA6	• No changes
 SA7	• If ICB commissioned MNVP services not in place, Trusts must escalate formally via PQSM. No further evidence required.
 SA8	• Improved technical guidance re: rotational medical staff, staff sickness/maternity leave, and neonatal resuscitation training.
 SA9	• Maternity and neonatal safety PQSM review by Boards required quarterly. • Perinatal leadership team includes MNVP.
 SA10	• Families to receive information in a format accessible to them, and a SMART plan must be shared with Board if not possible.

SA5 clarification

SA5	• Birthrate+ - Professional judgement of DOM/HOM

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.

*** BirthRate+ encourages the use of professional judgement in the final determination of maternity safe staffing levels in line with the safe staffing guideline.**

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.

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.

NHS Resolution

Safety Action 1

Prof Jenny Kurinczuk – National Programme Lead PMRT

Neonatal Transitional Care for Late Preterm Infants-why and how?

Elizabeth Pilling

Consultant Neonatologist

MIS 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?

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

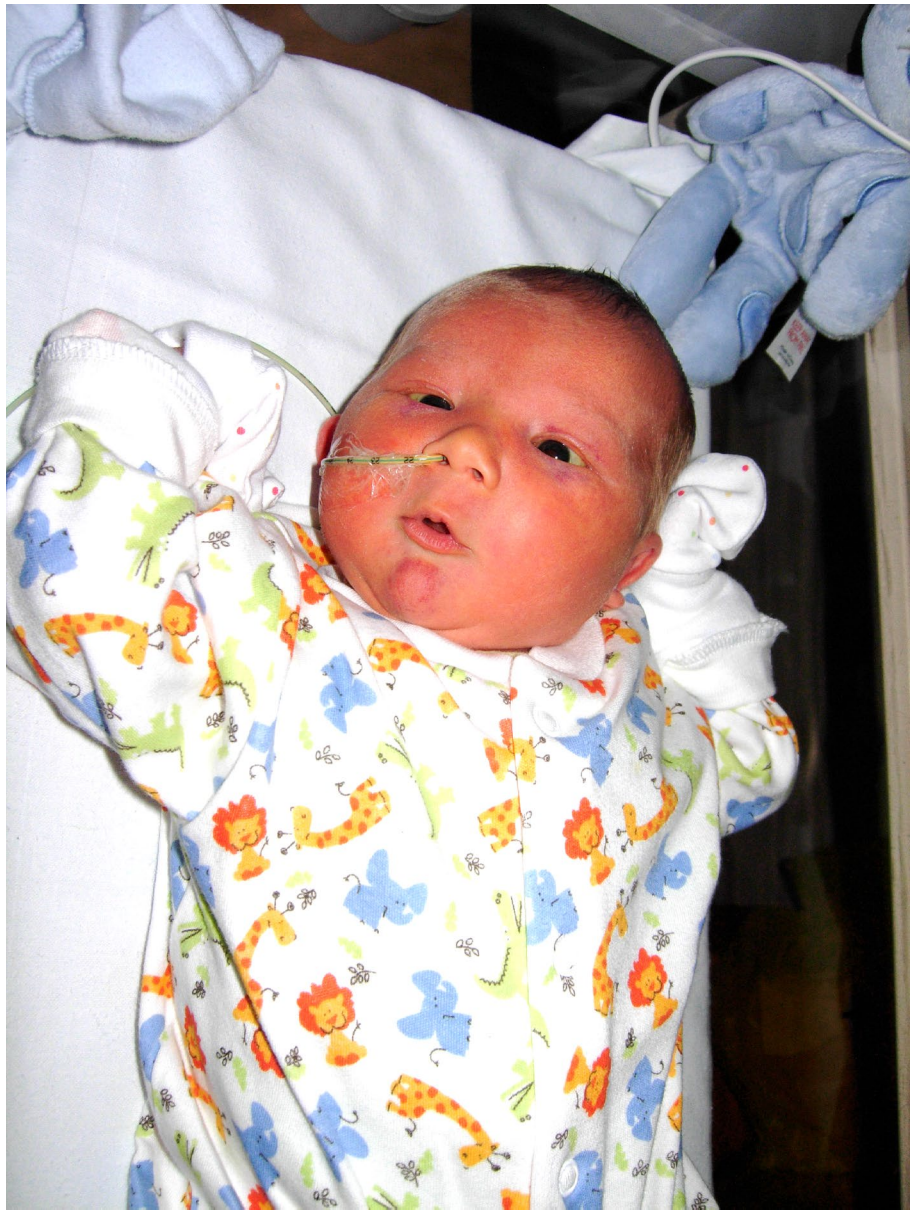
Be able to evidence progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice and submit this to your Trust and the Neonatal Operational Delivery Network (ODN) on behalf of the LMNS Boards.

What is “transitional care”?

Neonatal Transitional Care (NTC) is care additional to normal infant care, provided in a postnatal clinical environment by the mother or an alternative resident carer, supported by appropriately trained healthcare professionals [1]

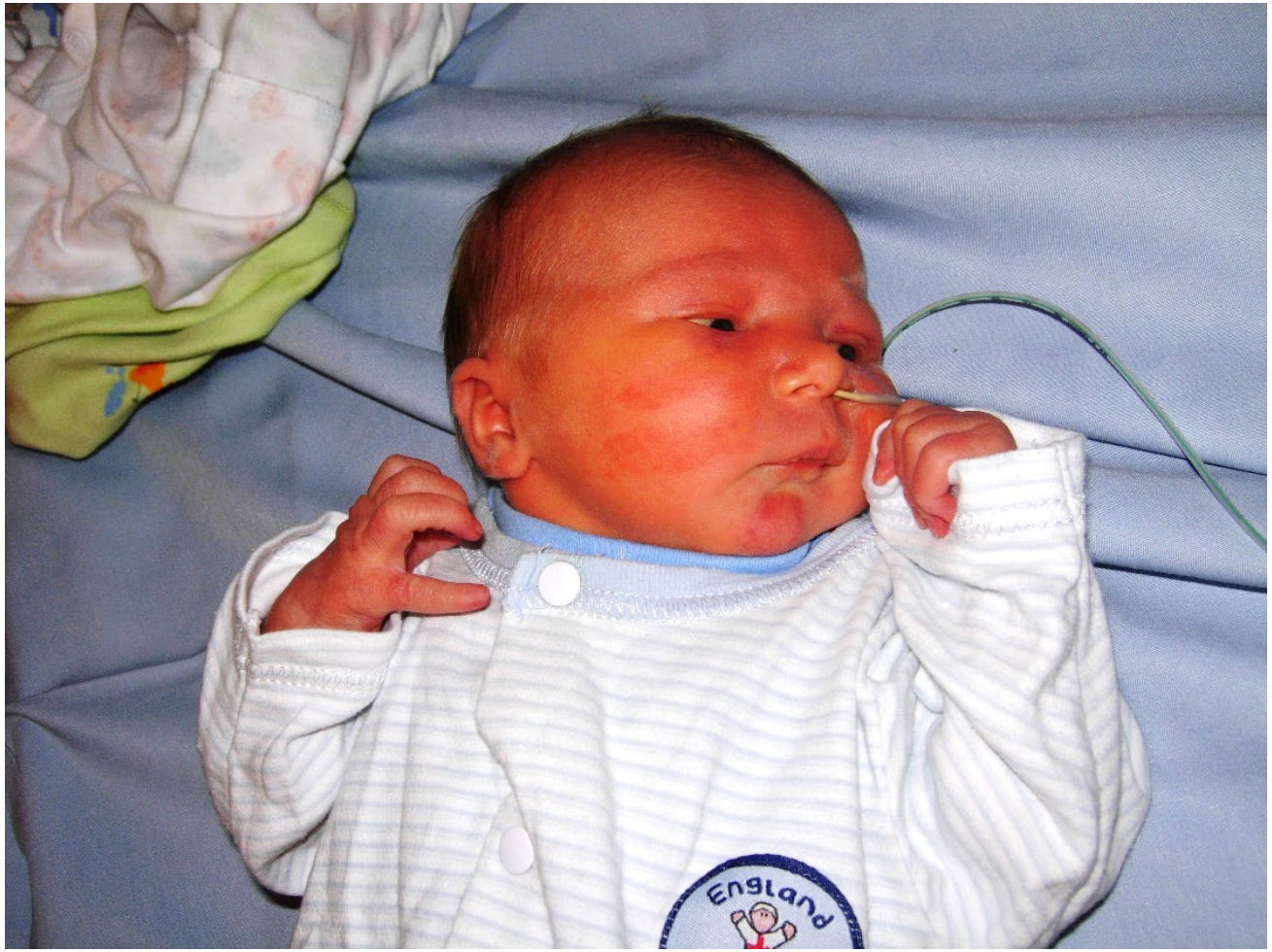
“A service not a place” [1]

Differs from paediatric wards- 2 “patients”



Which babies?

- Late preterm infants (34-35+6)/low birth weight (1600-2000g) from birth
- Term babies requiring additional support
  - Eg iv antibiotics, congenital anomalies needing NG feeding, jaundice, neonatal abstinence syndrome
- “step down” for preterm infants
  - Preparation for discharge home, establishing oral feeding



Why transitional care?

Neonatal Critical care review 2019 [2]

A seamless, responsive and multidisciplinary service built around the needs of new-born babies and the involvement of families in their care. High quality neonatal care will be networked together across England, to improve outcomes for all families, provide safe expert care as close to their home as possible, and keep mother and baby together while they need care

BAPM Service and Quality Standards for Provision of Neonatal Care in the UK November 2022 [3]

Each NNU should have arrangements to provide Neonatal Transitional Care for appropriate babies, thus minimising parent-baby separation

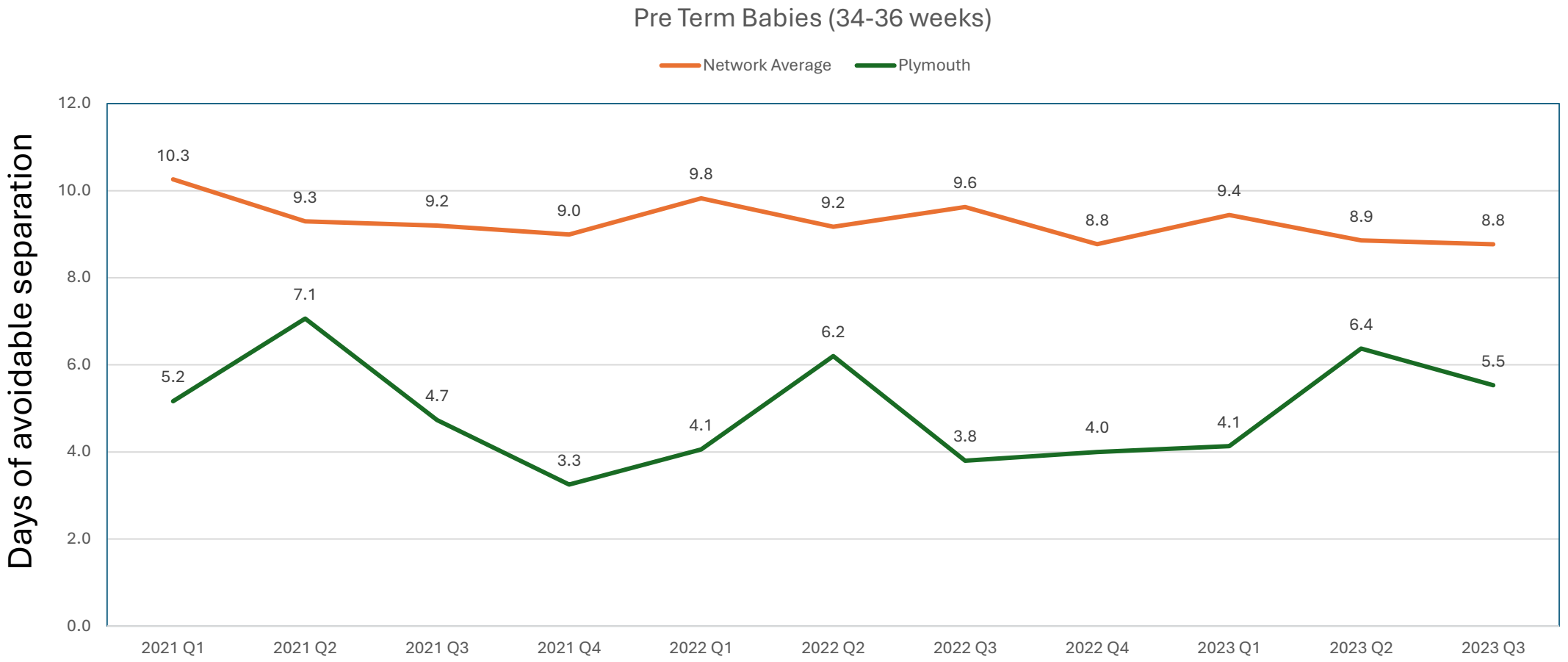
Neonatal Service Specification, NHS England March 2024[4]

The service will provide… transitional care, working in collaboration with postnatal services, subject to the commissioner agreed local service model and according to the BAPM Framework for Practice for Neonatal Transitional Care (2017)

ATAIN
(Avoiding term admissions in neonatal units)

- Initial key feature of Safety Action 3
- 2017 NDAU review [5]
  - “2/3 of babies admitted to NNU with jaundice could be managed in transitional care setting (2011-2013)”
- ATAIN analysis [6]
  - Reduction in term admissions to neonatal units between 2017-2021 from 5.4 to 4.8%
  - Equivalent to 8400 fewer babies requiring care on NNU
  - Reduction primarily in care days for “hypoglycaemia” and “infection”
  - 29% increase in babies admitted to TC recorded on Badgernet-NB may be data recording

LPI SW data – Plymouth with TC best performing [7]



Neonatal benefits [8]

- Supports infant/parent bonding
  - Avoids separation
  - Promotes parents as carers
- Increased breast feeding
  - Early contact after birth
  - Enhanced support for initiation of breast feeding
- Promotes family integrated care
  - Increased parental confidence
  - Supports additional health education eg NG feeding
  - Supports 2nd parent as carer
  - Improves bonding with siblings
- Reduced cross infection
  - Mother as primary carer

Organisational benefits

- Reduced length of stay
  - Earlier establishment of breast feeding
  - Increased parental confidence
- Increased availability of neonatal unit cots for preterm/sick neonates
  - ATAIN reduction of 8400 babies=23 cots a day
- Promotes MDT working between maternity and neonatal teams

How?

- Stand alone Transitional Care
  - Aligned focus
  - Builds expertise for “TC” families
  - Requires additional space/staffing
  - May not be appropriate for mothers with high care requirements

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  - Aligned focus
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- Within Postnatal Ward
  - Can accommodate mothers with higher care requirements
  - Within current estate
  - Can cause challenges with maternal bed occupancy when “fit for discharge”
  - Challenges readmitting well parents
  - visiting/resident rules for 2nd parent/siblings can differ for NNU v postnatal ward
  - Shared bays less suitable for longer stays

How?

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  - Challenges readmitting well parents
  - visiting/resident rules for 2nd parent/siblings can differ for NNU v postnatal ward
  - Shared bays less suitable for longer stays
- Within Neonatal Unit
  - Within neonatal nursing establishment
  - “rooming in” rooms can be used
  - Allows families to be together
  - Challenges with mothers with care requirements
  - Often not possible from day of birth
  - Already shortage of parental accommodation within neonatal units

Summary

- Transitional care has clear benefits for infants and families
- Establishment and ongoing management requires close working between the perinatal team

References

1 British Association of Perinatal Medicine A Framework for Neonatal Transitional Care October 2017

2 Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf

3 BAPM_Service_Quality_Standards_FINAL.pdf

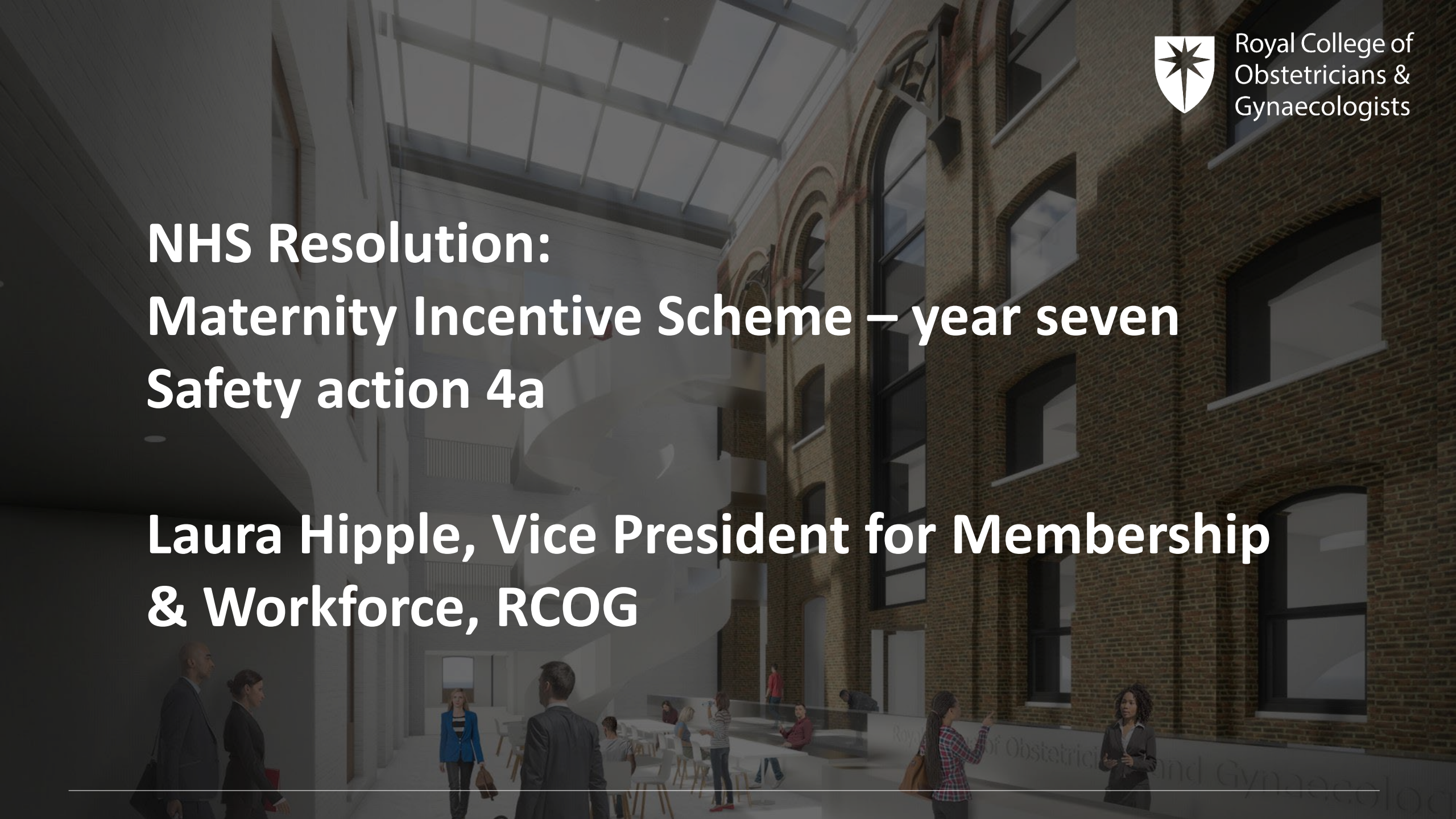
4 Neonatal-critical-care-service-specification-March-2024.pdf

5 Battersby C, Michaelides S, Upton M, et al. Term admissions to neonatal units in England: a role for transitional care? A retrospective cohort study. BMJ Open 2017;7:e016050. doi:10.1136/ bmjopen-2017-016050

6 ATAIN analysis Helen Theakston Data and Analytics (Maternity and Neonatal) NHS England (unpublished)

7 Plymouth/South West Neonatal ODN Data- Roisin McKeon-Carter personal communication

8 Does transitional care improve neonatal and maternal health outcomes? A systematic review British Journal of Midwifery • September 2013 • Vol 21, No 9



Royal College of Obstetricians & Gynaecologists

NHS Resolution: Maternity Incentive Scheme – year seven Safety action 4a

Laura Hipple, Vice President for Membership & Workforce, RCOG

Safety Action 4a, Obstetric Medical Workforce

Royal College of Obstetricians & Gynaecologists

MIS applies to all acute Trusts in England that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST).

'Can you demonstrate an effective system of clinical workforce planning to the required standard?'

This action encompasses 4 RCOG documents:

1)Certificate of Eligibility for Short-term Locums

2)Compensatory Rest

3)Guidance on the Engagement of Long-term Locums in Maternity Care

4)Roles and Responsibilities of a Consultant

1. Certificate of eligibility (CEL)

Trusts should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in O&G on tier 2 or 3 (middle grade) rotas:

a. currently work in their unit on the tier 2 or 3 rota **or**
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) **or**
c. hold a certificate of eligibility (CEL) to undertake short-term locums

www.rcog.org.uk/cel

Royal College of Obstetricians & Gynaecologists

CEL Queries

- CCT holders
- Definition short-term locum
- Trust versus locum agency responsibilities

www.rcog.org.uk/cel

cel@rcog.org.uk

Royal College of Obstetricians & Gynaecologists

2.RCOG Guidance on the engagement of long-term locums in maternity care

Royal College of Obstetricians & Gynaecologists

Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS Board.

In this guidance a long-term locum is one where a placement is greater than 2 weeks in duration.

This guidance recommends employing organisations offer locums support and supervision including:

- Departmental induction by a consultant on commencement date
- A named consultant supervisor
- Supernumerary clinical duties undertaken with direct supervision prior to commencing OOH duties
- Review of suitability for post and OOH working based on MDT feedback

3. Compensatory Rest

Royal College of Obstetricians & Gynaecologists

Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior 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.

When they are non-resident on-call, increased acuity, complexity and the appropriate focus on training and support for junior colleagues when activity levels are high have added to this need.

The decision to attend for an emergency at 2am should not be influenced by the necessity to attend clinical sessions the following day.

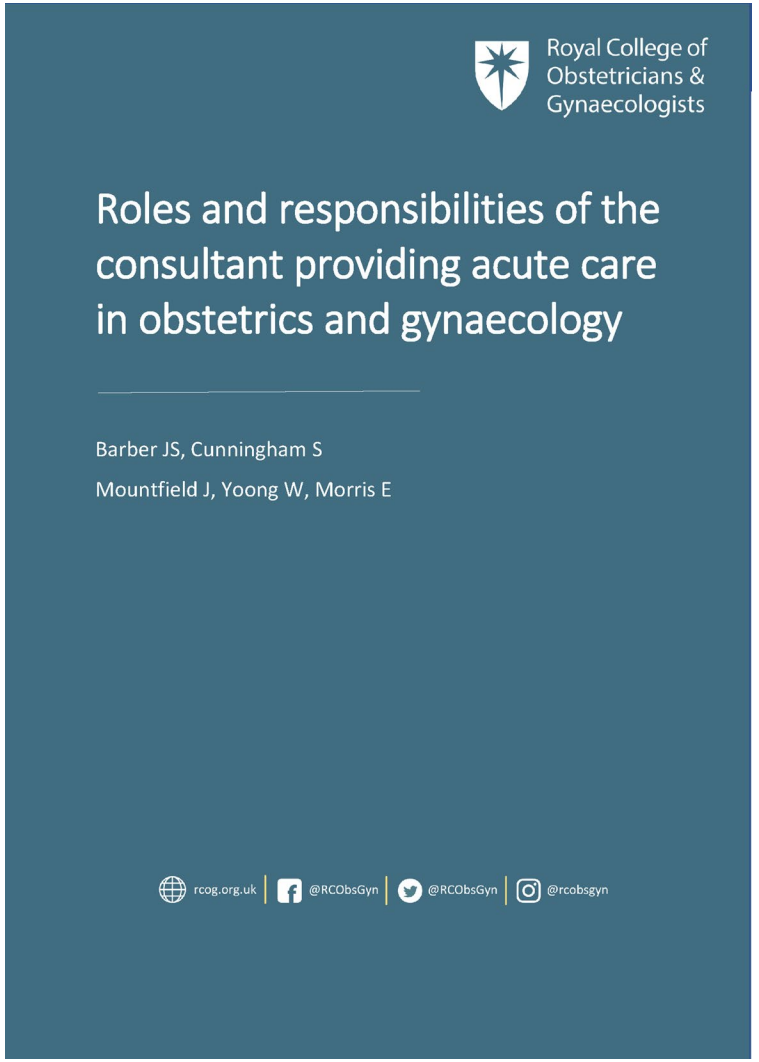
There is a need for appropriate and mandated compensatory rest for consultants following overnight non-resident on-calls.

Moving to a model that would allow for full implementation of the BMA guidance will take time, but we recommend that units look proactively at this issue as part of their ongoing job planning cycle.

4. Roles and Responsibilities

Trusts should ensure they are compliant with consultant attendance for the clinical situations listed in RCOG guidance for a minimum of 80% of applicable situations:
Roles and Responsibilities of a Consultant in O&G.

The role of the consultant encompasses that of a:
- senior and experienced clinician
- team leader and role model
- trainer and supervisor
- risk manager
- patient advocate
- innovator



Consultant attendance

Royal College of Obstetricians & Gynaecologists

Trusts should ensure they are compliant with consultant attendance for the clinical situations listed in RCOG guidance for a minimum of **80%** of applicable 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 nonattendance.

Situations in which the consultant must ATTEND unless the most senior doctor present has documented evidence as being signed off as competent.

In these situations, the senior doctor and the consultant should decide in advance if the consultant should be INFORMED prior to the senior doctor undertaking the procedure.

Saving Babies' Lives Care Bundle v3.2

28th April 2025

Presented by:
SBLCB Team, NHSE

Saving Babies' Lives v3.2

Introduction, rationale for v3.2 and overview of changes ..... Karen Thirsk (5 mins)

Element 4 updates to 'Fresh eyes' ..... Susie Crowe (5 mins)

Element 6 summary of changes..... Eleanor Scott (10 mins)

SBLCB Implementation Tool ..... Alanna Parker (5 mins)

Q&A's (5 mins)

Introduction and rationale for V3.2

- Published in June 2023, Version 3 of the Saving Babies Lives Care Bundle
- Independent evaluation of SBLCB V2
- V3.2 published April 2025 to reflect changes in national guidance / publications

Key changes in summary

- **Element 2:** to bring in line with publication of RCOG's Green-top Guideline 31 on Small-for-Gestational-Age and growth restricted foetuses in May 2024. Alongside changes to Element 2, guidance from the Chief Scientific Officer on the use of digital blood pressure monitoring in pregnancy is being refreshed to broaden the range of validated monitors available to trusts through the NHS Supply Chain.

- **Element 4:** to clarify and simplify requirements around clinical review, in particular 'Fresh Eyes', in view of frontline clinical feedback.

- **Element 5:** updates to interventions and associated measures to match NNAP standards and minimise the need for local audits; and to reflect the longer-term shortage of validated quantitative Fetal Fibronectin test kits following Hologic's decision to discontinue production; and remove requirements relating to Midwifery Continuity of Carer in view of revised Cochrane evidence.

- **Element 6:** replacing requirements around use of Continuous Glucose Monitoring with the use of Hybrid Closed Loop (HCL) systems for women with T1 diabetes in line with publication of the Diabetes Programme's 5 Year Implementation Strategy for Hybrid Closed Loop.

Element 4 updates to ‘Fresh eyes’

Susie Crowe, National Speciality Advisor Obstetrics

- New wording for Intervention 4.4:

  A separate clinical review should be undertaken to help provide an objective holistic review for example ‘Fresh Eyes’. This can also include obstetric reviews on ward rounds and when escalating clinical concerns to senior decision makers. This should be undertaken at least hourly when CTG monitoring is used and at least four hourly when IA is utilised, unless there is a trigger to provide a holistic review earlier.

- The audit evidence requirement has been removed from the Implementation Tool.

Element 6 Management of Diabetes in Pregnancy: summary of changes

Eleanor Scott, Professor of Medicine (Diabetes and Maternal Health)

HCL in T1D pregnancy – the clinical evidence

Professors Helen Murphy and Eleanor Scott

Professor of Medicine, University of East Anglia (UEA), Norwich UK, Honorary Consultant Physician,

Norfolk & Norwich University NHS Hospital Trust, Chair National Pregnancy in Diabetes (NPID) Audit

Professor of Medicine (Diabetes and Maternal Health), University of Leeds, Leeds teaching Hospitals

NHS Trust, Chair National GDM Audit

Women with T1D have large babies

- ~50% of babies Large for Gestational Age
- LGA associated with preterm birth, neonatal care unit admission, and birth injuries (shoulder dystocia/fetal hypoxia leading cause of NHS litigation £££)
- Predisposes offspring to developing obesity, type 2 diabetes and cardiovascular disease in later life…..

Nothmann M NEJM archive 1941;224: 275-280

Murphy HR et al. Lancet Diabetes and Endocrinology 2021; 9:153-164

Really difficult to manage T1D throughout pregnancy

1st trimester: HbA1c <48 mmol/mol (<6.5%)

Tighter CGM pregnancy targets 70% TIRp

2nd – 3rd trimester: HbA1c <43 mmol/mol (<6.0%)

Changing insulin sensitivity & rising post-meal resistance

Increased day to day variability

Fear of **hyperglycaemia** and effect on baby

Gestation	What to expect?
4-8 weeks	Very labile levels
8-16 weeks	Increased insulin sensitivity ~ hypos
16 weeks +	Increasing insulin resistance ~ every few days
End of 3rd trimester	Increase in insulin sensitivity
Post-partum	Immediate decrease in insulin doses

Huge mental burden of self-management

Mc Lean A et al Diabetologia 2024, Lawton J et al DTT 2023

Unequivocal evidence on the clinical & health economic benefits of using CGM to improve maternal glucose and neonatal outcomes in T1D pregnancy

Continuous glucose monitoring in pregnant women with type 1 diabetes (CONCEPTT): a multicentre international randomised controlled trial

*Denice S Feig, Lois E Donovan, Rosa Corcoy, Kellie E Murphy, Stephanie A Amiel, Katharine F Hunt, Elizabeth Asztalos, Jon F R Barrett, J Johanna Sanchez, Alberto de Leiva, Moshe Hod, Lois Jovanovic, Erin Keely, Ruth McManus, Eileen K Hutton, Claire L Meek, Zoe A Stewart, Tim Wysocki, Robert O'Brien, Katrina Ruedy, Craig Kollman, George Tomlinson, Helen R Murphy, on behalf of the CONCEPTT Collaborative Group**

Summary

Background Pregnant women with type 1 diabetes are a high-risk population who are recommended to strive for optimal glucose control, but neonatal outcomes attributed to maternal hyperglycaemia remain suboptimal. Our aim was to examine the effectiveness of continuous glucose monitoring (CGM) on maternal glucose control and obstetric and neonatal health outcomes.

Lancet 2017; 390: 2347–59

Published Online September 15, 2017 http://dx.doi.org/10.1016/S0140-6736(17)32400-5

Feig DS et al. Continuous glucose monitoring in pregnant women with Type 1 diabetes (CONCEPTT): a multicentre randomised controlled trial. Lancet. 2017;390, 2347-2359

Murphy HR et al. Modelling potential cost savings from use of real-time continuous glucose monitoring in pregnant women with Type 1 diabetes. Diabetic Medicine 2019;36(12):1652-1658

NATIONAL DIABETES AUDIT

95% of women with **type 1** diabetes wore **continuous glucose monitors** in 2022

95%

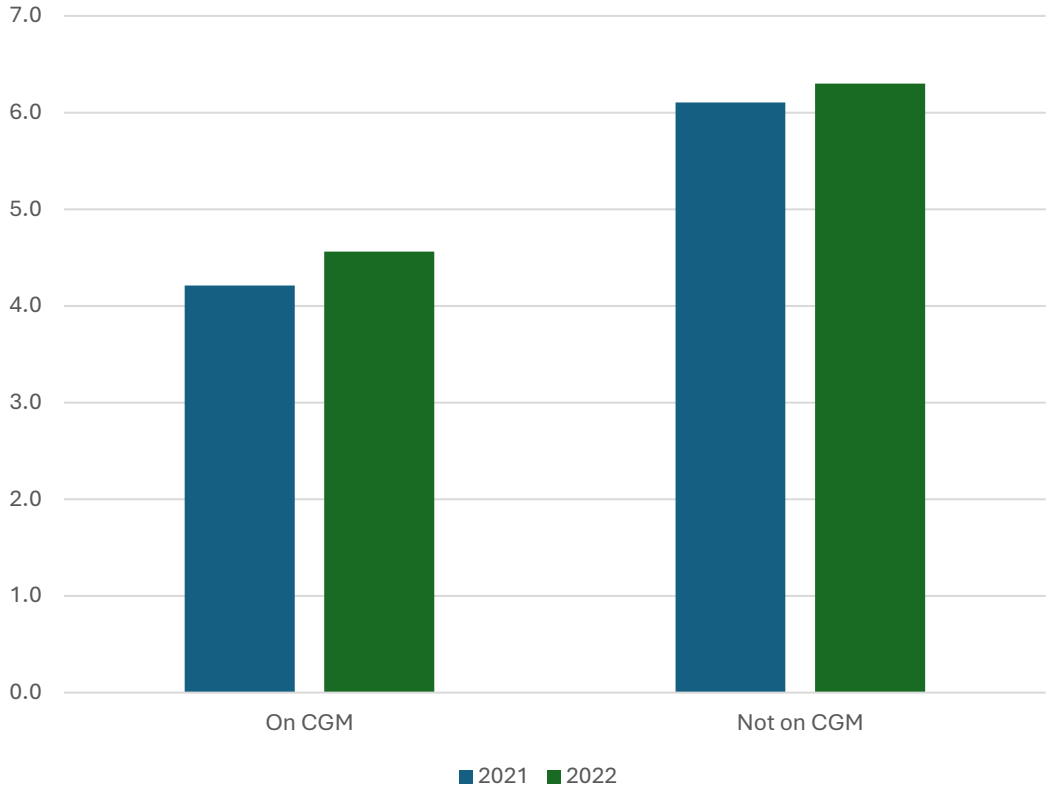
Real-world CGM use – N=2055

NATIONAL DIABETES AUDIT

Wearing continuous **glucose montiors** improved:

- **glucose levels** for mothers
- **outcomes** for women and babies

Serious adverse pregnancy outcomes (Birth defects, stillbirth, baby death)



Improved pregnancy glucose levels with:

- ✓ Fewer LGA babies
- ✓ Fewer preterm births
- ✓ Fewer neonatal care admissions

Scott EM, Murphy HR, Kennedy K, Kar P. CONCEPTT to care: the science of implementation in diabetes care. Lancet Diabetes Endocrinol. 2024 Feb 26:S2213-8587(24)00039-1.

Combining CGM as part of a Hybrid Closed Loop automated insulin delivery system improves maternal glucose more

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

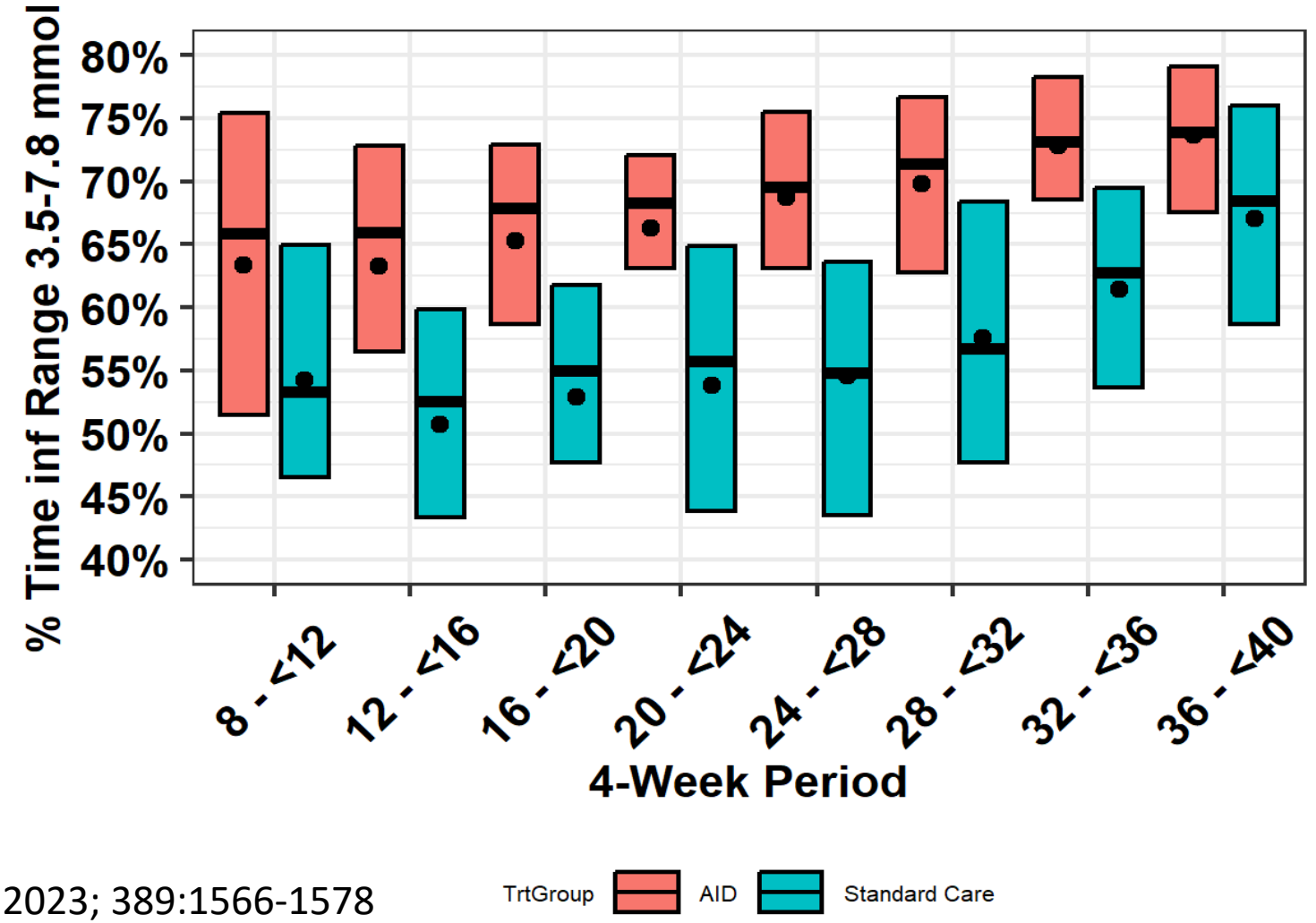
Automated Insulin Delivery in Women with Pregnancy Complicated by Type 1 Diabetes

Tara T.M. Lee, M.B., B.S., Corinne Collett, B.Sc., Simon Bergford, M.S., Sara Hartnell, B.Sc., Eleanor M. Scott, M.D., Robert S. Lindsay, Ph.D., Katharine F. Hunt, M.D., David R. McCance, M.D., Katharine Barnard-Kelly, Ph.D., David Rankin, Ph.D., Julia Lawton, Ph.D., Rebecca M. Reynolds, Ph.D., Emma Flanagan, Ph.D, Matthew Hammond, M.Sc., Lee Shepstone, Ph.D., Malgorzata E. Wilinska, Ph.D., Judy Sibayan, M.P.H., Craig Kollman, Ph.D., Roy Beck, Ph.D., Roman Hovorka, Ph.D., and Helen R. Murphy, M.D., for the AiDAPT Collaborative Group*

AiDAPT

Lee T et al N Engl J Med 2023; 389:1566-1578

CamAPS FX HCL improved maternal glucose from early pregnancy compared to using just CGM

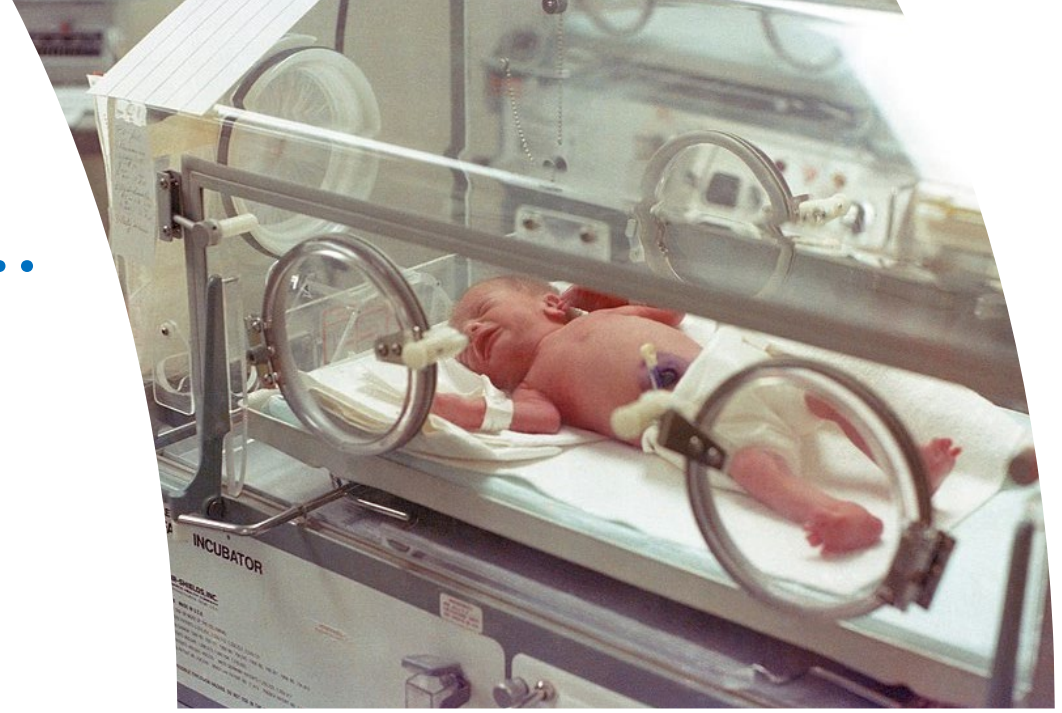


Lee T et al N Engl J Med 2023; 389:1566-1578

AiDAPT

Additional benefits of HCL compared to using just CGM.....

- ✓ 3.7kg less gestational weight gain
- ✓ Less gestational hypertension
- ✓ Low rates of LGA/NICU
- ✓ Less worry, less work, more enjoyable pregnancy



Listening to women: experiences of using closed-loop in type 1 diabetes pregnancy

Lawton J et al Diabetes Technology & Therapeutics 2023 25:12, 845-855

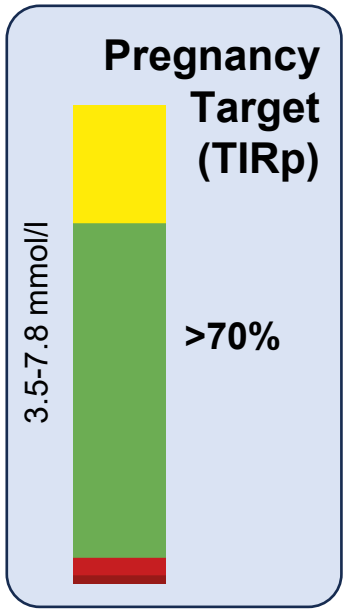
AiDAPT

CamAPS FX is a Pregnancy-specific HCL

- ✓A license for use in pregnancy
- ✓A glucose target of ≤5.0 mmol/l
- ✓Clinically relevant improvement in maternal glucose (>5% extra time in the T1D pregnancy range) compared to CGM & MDI/Pump

AiDAPT

Other HCL systems that haven't been developed for pregnancy lower glucose too little, too late



CamAPS FX: 70% TiRp ~16 weeks

Other HCL systems: 70% TIRp32-36 weeks

"Important to refine the algorithm to better align with pregnancy requirements"

HCL benefits during pregnancy are system specific

CamAPS FX	Other HCL systems
39% LGA	69% LGA
3.7kg less weight gain	5.4kg more weight gain

Lee T et al AiDAPT N Engl J Med 2023

Women with HbA1c>6.5%*
Quiros C et al Diabetes Technol Ther. 2024

SWAP to CamAPS FX HCL during pregnancy

SWAP to CamAPS FX

*"Any intervention must be based on a shared decision-making process, ensuring the patient is aware of **all options** and supported to make an **informed choice**"*

Carefully consider Montgomery ruling...

https://services.nhslothian.scot/maternity/wp-content/uploads/sites/62/2022/09/RCOG-Impact-of-Montgomery-Ruling.pdf

Differences between HCL systems
A pregnancy decision tool

	Cam APS FX (Ypsomed or Dana)	Medtronic 780G	Tandem IQ	Diabeloop	Omnipod 5	Current standard care CGM (with MDI or Pump)
Licensed for use in pregnancy	☑	☒	☒	☒	☒	☑
Achieves glucose target of ≤5.0 mmol/l	☑ 4.4	☒ 5.5	☒ 6.25	☒ 5.6	☒ 6.1	☒
Evidence for clinically relevant improvement in maternal glucose outcomes (>5% improvement in TIRp 3.5-7.8) irrespective of age, BMI, booking HbA1c	☑ NEJM 2023	☒ Lancet D&E 2024; DTT 2024	☒ DTT 2024	☒ DTT 2024	☒	☑ Lancet 2017
Achieves time in pregnancy glucose range (3.5-7.8) TIRp >70% from first trimester	☑ Achieved in 1 in 2	☒ Achieved 1 in 20 in women with early pregnancy HbA1c >6.5%	☒	☒	☒	☒
Chance of having a big baby (Large for Gestational Age)	1 in 3 LGA rates 39%	2 in 3 LGA rates 60-70%	2 in 3 LGA rates 60-70%	2 in 3 LGA rates 60-70%	Unknown	1 in 2 LGA rates 50%
Maternal weight change in pregnancy	**3.7 kg less weight gain**	5.4 kg **more** weight gain in women with early pregnancy HbA1c >6.5%, and 3.3kg more if HbA1c <6.5%	3.3- 5.4 kg **more** weight gain	3.3- 5.4 Kg **more** weight gain	Unknown	Neutral
Development of any hypertensive disorder in pregnancy	20%		Unknown	Unknown	Unknown	42%

Lee TTM et al. **N Engl J Med**. 2023 , Benhalmina K et al. **Lancet Diab and Endo**. 2024, Quirós C et al. **Diabetes Technol Ther**. 2024 Feig DS et al **Lancet**. 2017

Saving Babies Lives Care Bundle Version 3.2 January 2025

- Element 6 (Diabetes) has been updated to reflect NHS England's 5-Year Implementation Strategy for hybrid closed loop technologies, published in January 2024
- Pregnant women with T1D are identified as a priority population group for rollout
- Women with T1D should be offered a pregnancy-specific HCL system and be provided with appropriate education and support to use this (pregnancy-specific HCL is defined as above)
- Any pregnancies where HCL was not offered in line with the above should be subject to case review to determine service-level issues which could be addressed

Implementation Tool

- There is no change in functionality of the tool.

- We have focused on reducing burden for providers by, where possible:
  - Reducing / removing audits
  - Aligning with existing data sets
  - Making evidence collection less onerous

- We have added new graphs to show the proportion of interventions that are fully, partially or not implemented by element and fixed the bar graph on the ‘Progress and LMNS Review Record’ tab.

- A blank version of the updated tool will be added to your folders on the SBLCB NHS Futures Hub for you to start using by summer 2025.

Implementation Tool

Example of a change made to the tool:

v3

Inter-vention Ref	Required SBL Intervention	Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)
4.4	A buddy system should be used to help provide an objective holistic review for example 'Fresh Eyes' – this should be undertaken at least hourly when CTG monitoring is used and at least four hourly when IA is utilised, unless there is a trigger to provide a holistic review earlier.	Percentage of women birthed that had an hourly fresh eyes on all intrapartum CTGs or 4 hourly fresh eye review when IA is utilised	Introduce a Buddy system to pair up more and less experienced midwives during shifts to provide accessible senior advice with protocol for escalation of any concerns.	N/A	**Numerator:** Number of audited records that had a documented fresh eye review within required timeframe of fetal heart rate or categorisation of CTG and risk factors and any required escalation in line with clinical guidance **Denominator:** Number of women who have given birth in the period of review that were included within the audit A discussion between the midwife caring for the woman and another midwife or doctor should include the FHR (IA or CTG), review of antenatal risk factors such as concurrent reduced fetal movements, fetal growth restriction, previous caesarean birth; and intrapartum risk factors such as meconium, suspected infection, vaginal bleeding or prolonged labour and should lead to escalation if indicated (Appendix E).	Guideline evidencing 'fresh eye' review and required frequency. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 95% for high performing organisations with minimum ambition of 80%, with a clear action plan to achieve 95% reliability, for those organisations on an improvement journey.

v3.2

4.4	A separate clinical review should be undertaken to help provide an objective holistic review for example 'Fresh Eyes'. This can also include obstetric reviews on ward rounds and when escalating clinical concerns to senior decision makers. This should be undertaken at least hourly when CTG monitoring is used and at least four hourly when IA is utilised, unless there is a trigger to provide a holistic review earlier.	N/A	N/A	N/A	A discussion between the midwife caring for the woman and another midwife or doctor should include the FHR (IA or CTG), review of antenatal risk factors such as concurrent reduced fetal movements, fetal growth restriction, previous caesarean birth; and intrapartum risk factors such as meconium, suspected infection, vaginal bleeding or prolonged labour and should lead to escalation if indicated (Appendix E). Organisations to use local Quality Improvement to improve adherence to the guidelines if issues are raised through governance processes.	Guideline evidencing intrapartum fetal surveillance including clinical escalation to senior decision makers.

Thank You

Any Questions?

england.maternitytransformation@nhs.net

future.nhs.uk/SavingBabiesLives

Maternity Incentive Scheme

Year 7

Safety Action 7

Listen to women, parents and families using maternity and neonatal services and co-produce services with user

Alison Talbot, Deputy Chief Midwifery Officer
Cathy Brewster, National MNVP Service User Representative

Required Standard

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.

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

***All MNVPs are required to be commissioned and functioning in line with the MNVP guidance by the end of the Three-Year Delivery Plan in March 2026**

What?

MNVP funded and user-led in line with MNVP guidance (2023) to function as a professional, strategic and equitable programme of work

Appropriately commissioned by ICB with Trust to escalate and highlight gaps in MNVP implementation

Clear processes for hearing from maternity and neonatal service users and involving them in co-production and decision making.

Why? Values

- **Listen to service users** - Theme of major independent investigations
- **Representing diverse voices** - to reduce health inequalities
- **Quality oversight of services** - to review data, intelligence and feedback through a service user voice lens, providing analysis, advice and challenge
- **Collaborate with providers** - to find solutions and improvements based on real experiences
- **Challenge and influence change -** by advocating for improvements locally, ensuring equity, accessibility, safety, and personalisation

Why? Policy context

Statutory Guidance - The legal duties on public involvement require organisations to make arrangements to secure that people are appropriately 'involved' in planning, proposals, and decisions regarding NHS services

Three-year Delivery Plan – sets out expectations to better involve service users; expectations of the ICB's; integration of neonatal services

MNVP Guidance – Guidance to ICB's on fulfilling statutory obligations and Three-year Delivery Plan.

NHS Resolution Maternity Incentive Scheme – Providers need to ensure MNVPs function is in line with these guidance's

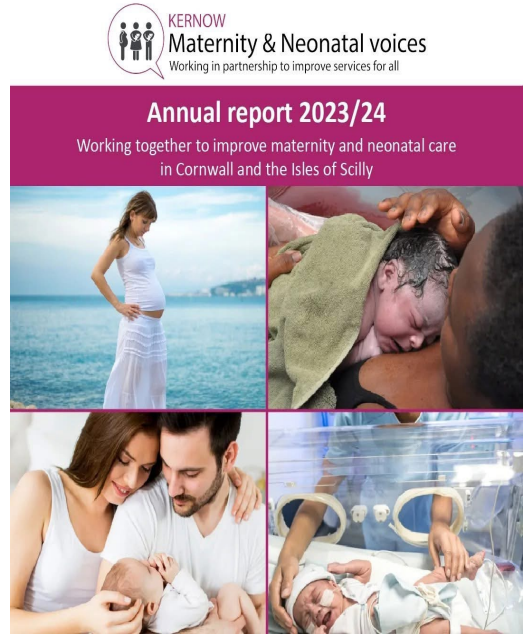
Impact

Well-resourced MNVP

- Culture of curiosity
- Authentic and diverse service user voice
- Influential in-service improvement
- Builds trust and transparency
- Better outcomes

Poorly resourced MNVP

- Closed culture
- Missed voices, especially from marginalised communities
- Missed warning signs
- Poorer engagement and trust
- Less effective transformation



A well-resourced MNVP is a lifeline between communities and healthcare services, driving safer, fairer, and more person-centred care. Without one, services risk becoming disconnected, inequitable, and less responsive to the people they are meant to serve

Aspect	Well-Resourced MNVP	Poorly Resourced / Absent MNVP
Voice of the Community	Diverse voices, especially from marginalized groups, are heard and valued	Only a narrow group of voices heard (or none at all); underserved voices missed
Influence on Services	Active involvement in co-production and service design	Little to no influence on decision-making
Safety & Quality	Regular feedback helps identify issues early and improve care safety	Missed feedback can lead to safety risks and unmet needs
Equity of Care	Helps expose and address health inequalities	Inequities go unchallenged, leading to gaps in care and poorer outcomes
Trust & Relationships	Builds trust and transparency between families and providers	Low engagement and trust; families feel disconnected from services
Support for Improvements	Informs policies, staff training, patient information, and communication tools	Change initiatives may lack user insight, making them less effective or off-target
Emotional & Mental Wellbeing	Families feel seen, heard, and supported	Parents may feel isolated, unheard, or traumatised by their experiences
Sustainability of Services	Community buy-in strengthens long-term improvements	Poor feedback loops make change harder to sustain or scale

Aspect	MNVP commissioned and functioning in line with guidance	MNVP *not* commissioned and functioning in line with guidance
Strategic Leadership	Employed, professional senior lead with lived experience	Lead by people on PPV or remunerated volunteers OR led by clinicians or people *without* lived experience
Contracting	Robust commissioning process leading to awarding of contract for service OR employment contracts	No robust commissioning process, no contracts or inappropriate contracts in place
Recruitment	Agreed and banded job descriptions, values-based recruitment process	No transparent recruitment process, job description absent or not reflective of development of role from chair to lead
Team	Team with capacity and the right skill mix including strategic leadership, programme management, engagement, data analysis, comms and marketing	Relying on a single individual or volunteers to deliver critical functions, lack of capacity
Support functions	IT, HR, accounts, training, admin provided in house through direct employment or through commissioning arrangements	Non-existent or slow to respond support functions
Governance meetings	Strategic Lead with capacity and capability to consistently attend and meaningfully contribute	Lack of seniority, experience and knowledge in strategic leadership and limited time to attend
Personal wellbeing & development	Regular access to supervision, wellbeing support, training & development opportunities	Limited or no process in place for support

Case study: Kernow MNVP

KERNOW Maternity Voices

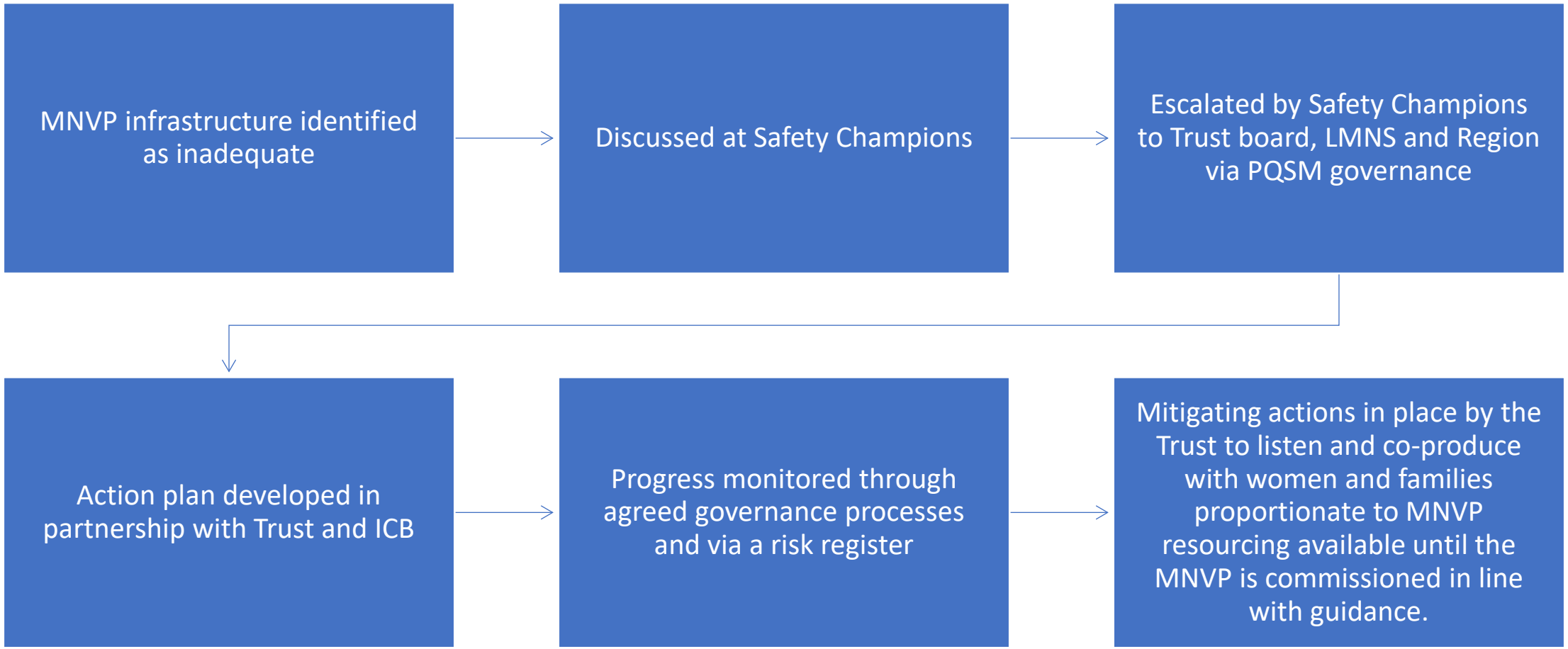
Working in partnership to improve maternity services

NHS England

- Cornwall and the Isles of Scilly ICB used national MNVP Guidance to influence the development of their MNVP service specification view service spec on NHS Futures.
- Two-year contract period commissioned with external organisation Evolving Communities
- £130,000 per annum plus contract variation to include Spring Budget funding
- Commissioned support includes admin, business support, comms, research support, training resources, IT and hardware, HR, effective and appropriate line management and policies such as privacy policy and expenses policy.

Job	WTE	Equivalent banding
MNVP senior lead for Maternity	0.7 WTE	8a
MNVP senior lead for Neonatal	0.4 WTE	8a
Coproduction and project lead	0.7 WTE	7
Engagement lead	0.6 WTE	5
Volunteer and project officer	0.4 WTE	5

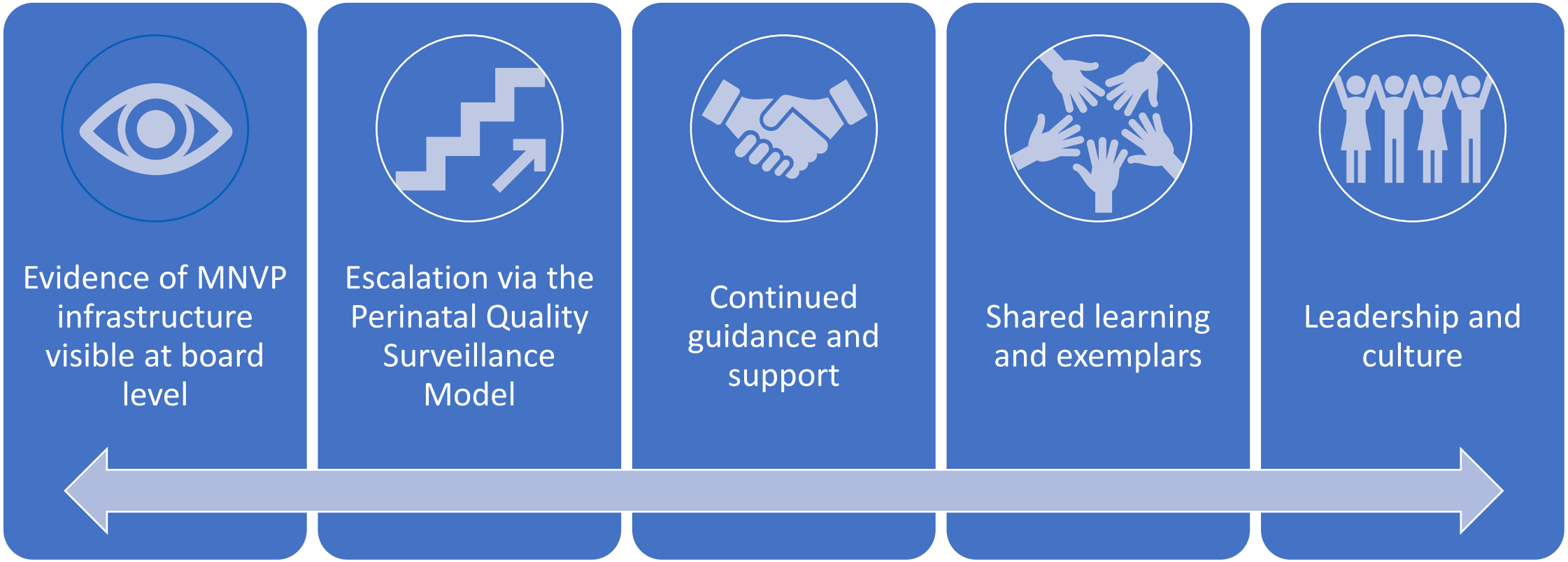
Escalation (see technical guidance)

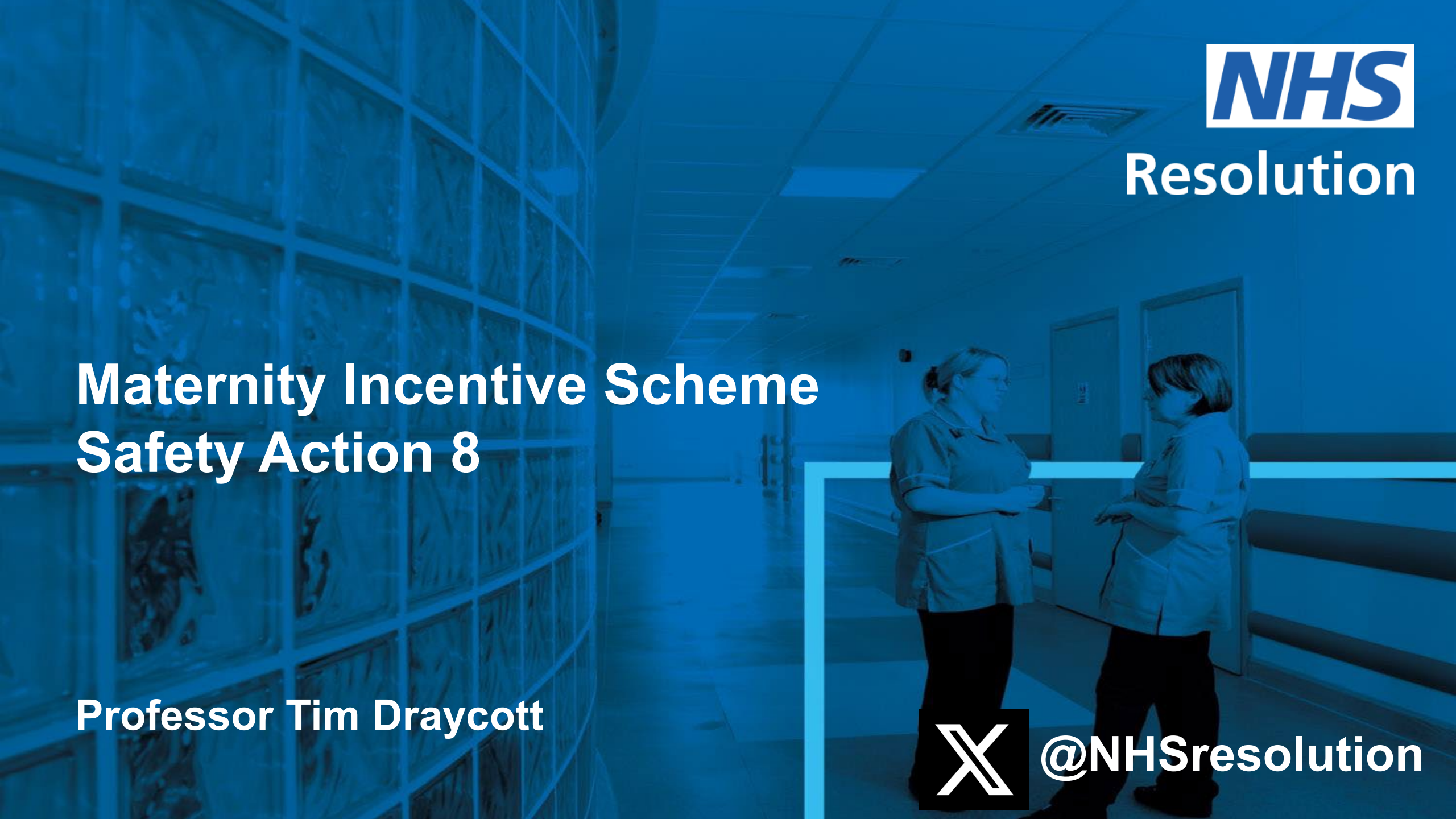


Challenges

- MIS is incentivising trusts not ICBs where MNVP commissioning responsibility lies
- Presence and extent of key enablers vary
- Lack of guidance mandating requirements of the MNVP team roles i.e. WTE, banding, role expectations
- Uncertain NHS England & ICB landscape
- Ongoing financial challenge at all levels including 50% ICB cuts

Solutions


Evidence of MNVP infrastructure visible at board level
Escalation via the Perinatal Quality Surveillance Model
Continued guidance and support
Shared learning and exemplars
Leadership and culture



NHS Resolution

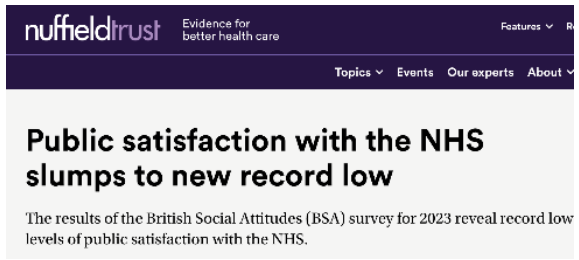
Maternity Incentive Scheme Safety Action 8

Professor Tim Draycott

@NHSresolution

Current tough times in maternity

- Acknowledge service is struggling
- Staffing challenges
- Litigation costs
- Confidence in the service
- Multiple investigations



Role of NHS Resolution

- Indemnifiers are not:
  - Professional bodies
  - Clinical guideline producers
  - Researchers
  - Regulators
  - Family representatives

What can NHS Resolution do?

- Claims based data
  - Narrow retrospective lens
  - An important lens nonetheless
- Share innovations and initiatives
  - Catalyse innovation to prevent neonatal brain injury
  - Incentivise best care
  - Address increasing litigation costs
  - Investigate restorative approaches after harm

Maternity Incentivisation Scheme (MIS)

- MIS linked to contributors to hypoxic brain injury/Mat Safety
- Curated 10 Safety Actions from system stakeholders
- 100% participation from Maternity Units in England
- Evaluation
- Similar systems in Australia, USA and planned in Ireland

MIS 10 safety actions

NHS Resolution

Safety action 1:
National Perinatal Mortality Review Tool

MBRRACE-UK

Safety action 2:
Data and the Maternity Services Data Set

NHS England

Safety action 3: Transitional care & avoiding term admissions

NHS England

Safety action 4: Clinical workforce planning

RCOA

Royal College of Obstetricians & Gynaecologists

Safety action 5: Midwifery workforce planning

Royal College of Midwives

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

NHS England

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

NHS England

Safety action 8:
Training

Royal College of Obstetricians & Gynaecologists

NHS England

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

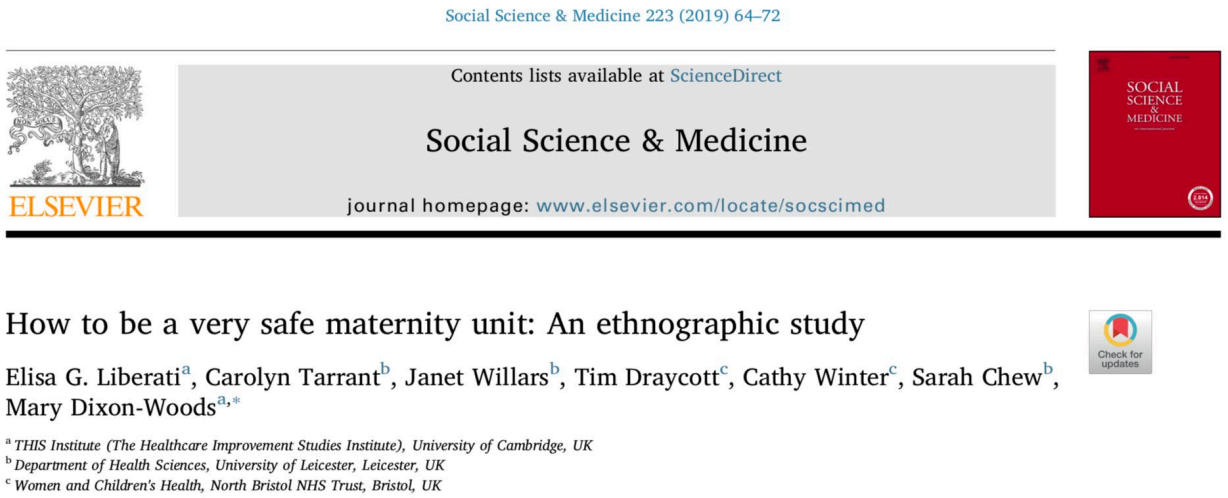
NHS England

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

MNSI Maternity & Newborn Safety Investigations

NHS Resolution

What makes a maternity unit safe?



Social Science & Medicine 223 (2019) 64–72

Contents lists available at ScienceDirect

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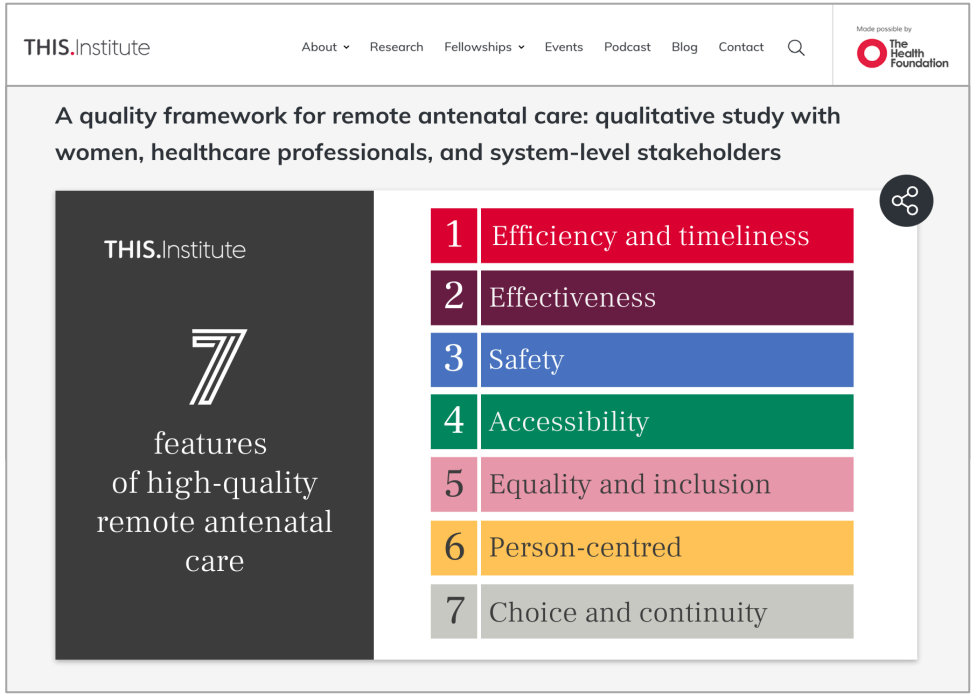
journal homepage: www.elsevier.com/locate/socscimed

How to be a very safe maternity unit: An ethnographic study

Elisa G. Liberati[a], Carolyn Tarrant[b], Janet Willars[b], Tim Draycott[c], Cathy Winter[c], Sarah Chew[b], Mary Dixon-Woods[a,*]

[a] THIS Institute (The Healthcare Improvement Studies Institute), University of Cambridge, UK
[b] Department of Health Sciences, University of Leicester, Leicester, UK
[c] Women and Children's Health, North Bristol NHS Trust, Bristol, UK

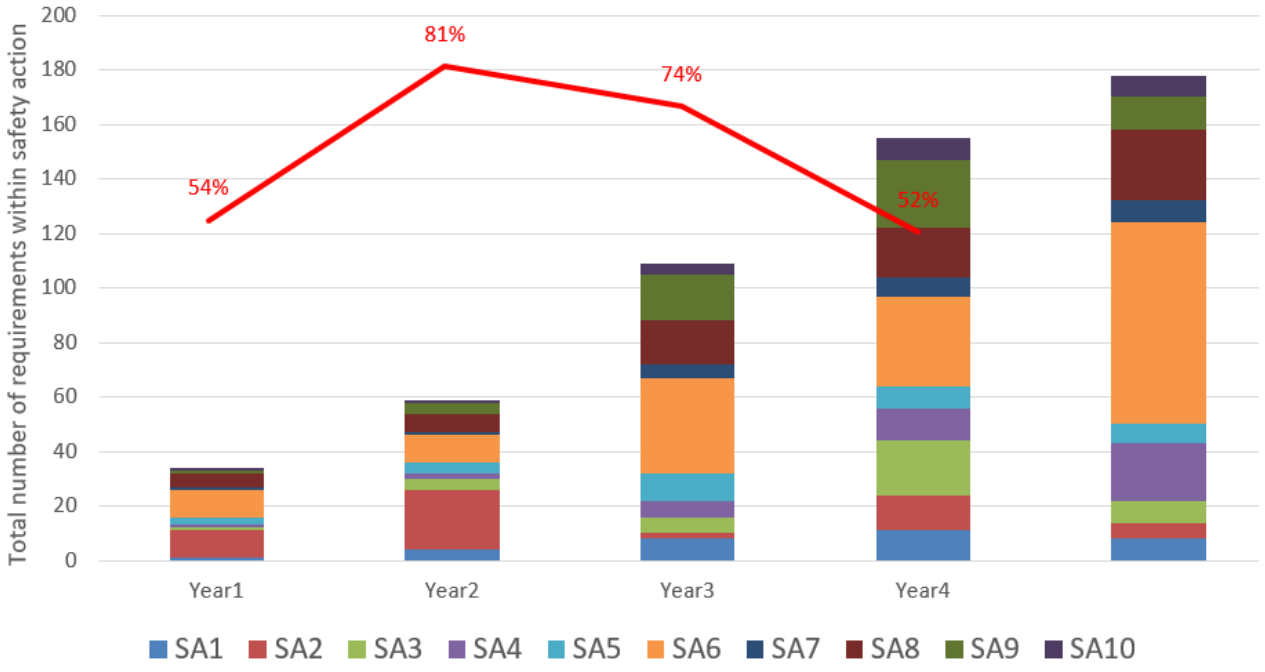


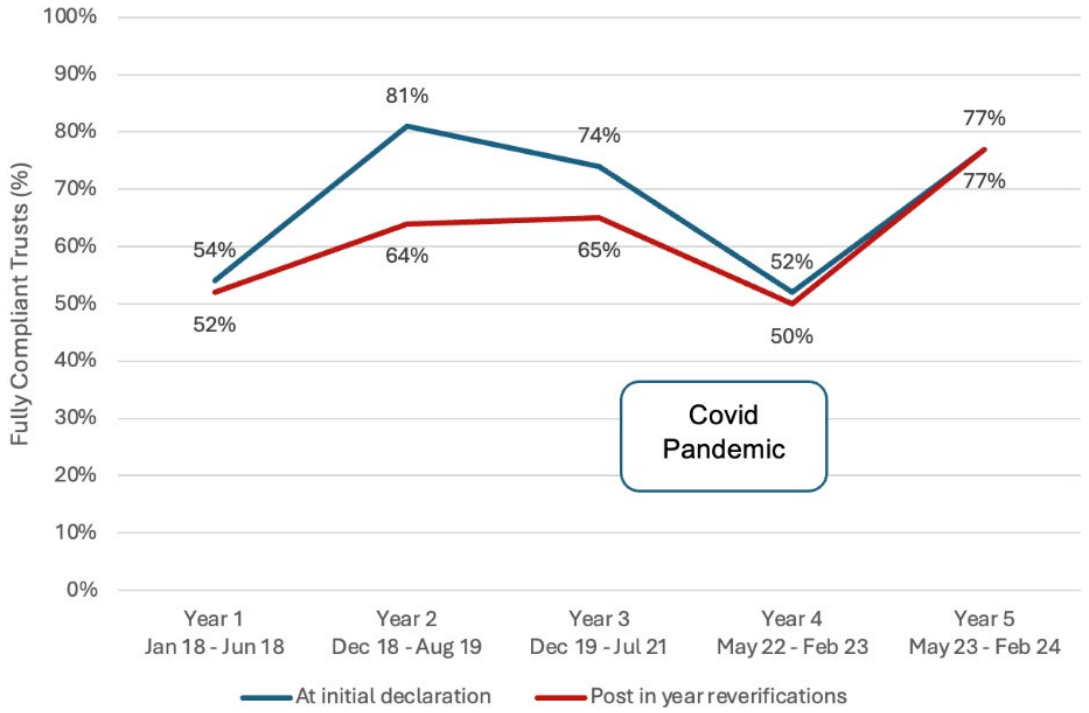
- Social, organisational and cultural factors
- Staffing levels
- The physical environment
- Local multi-professional training

Consistent national themes – 'Training'

Kirkup report Morecambe Bay (2015)	Highlighted **systemic failures in training**, including inadequate staffing levels and poor supervision.
Ockenden reports Shrewsbury & Telford (2020 & 2022)	Emphasised the need for comprehensive **training in basic midwifery skills**, risk assessment, and communication.
Reading the Signals East Kent (2022)	Highlighted the importance of **training in clinical skills**, recognising deteriorating patients, and trauma-informed care.
All-Party Parliamentary Group on Birth Trauma Report (2024)	Emphasised the importance of **training healthcare professionals** in recognising and responding to the psychological impact of birth trauma.
CQC National review of maternity services in England 2022 to 2024 (2024)	Identified that some **staff lacked the necessary training** to provide safe and effective care in areas such as fetal monitoring, recognising and responding to deteriorating patients, and communication skills. The report also highlighted the impact on staff wellbeing when they felt unable to deliver high-quality care.
MBRRACE-UK reports (all)	Continuously highlights the **need for improved training** in risk assessment, early warning systems, and emergency response.
Nottingham Maternity Review (Emerging findings - ongoing)	Focussing on the **need for training** in fetal monitoring, shoulder dystocia management, and cultural competency.
Maternity & Newborn Safety Investigations (MNSI) Annual Report (November 2024)	Emphasises the **need for improved training** in clinical assessment and fetal monitoring, as well as better escalation and clinical oversight practices. Highlights the significance of risk assessment training. Notes that these are recurrent themes.

Safety Actions





How has SA8 evolved?

NHS Resolution

Year 1

- 90% attendance at 'in-house' MDT maternity emergencies training session within year

Year 2

- **PLUS**
- Includes fetal monitoring in labour in day
- Integrated team-working
- Simulated emergencies and/or hands-on workshops

Year 3

- **PLUS**
- Covid-19 specific e-learning
- Neonatal resuscitation for team involved in immediate resuscitation
- Commitment to facilitate MDT training

Year 4

- **PLUS**
- 90% of all staff attending neonatal resuscitation
- 90% of all staff attending separate one day multi-professional training day that includes antenatal and intrapartum fetal monitoring
- Training plan for compliance with 6 core modules of Core Competency Framework

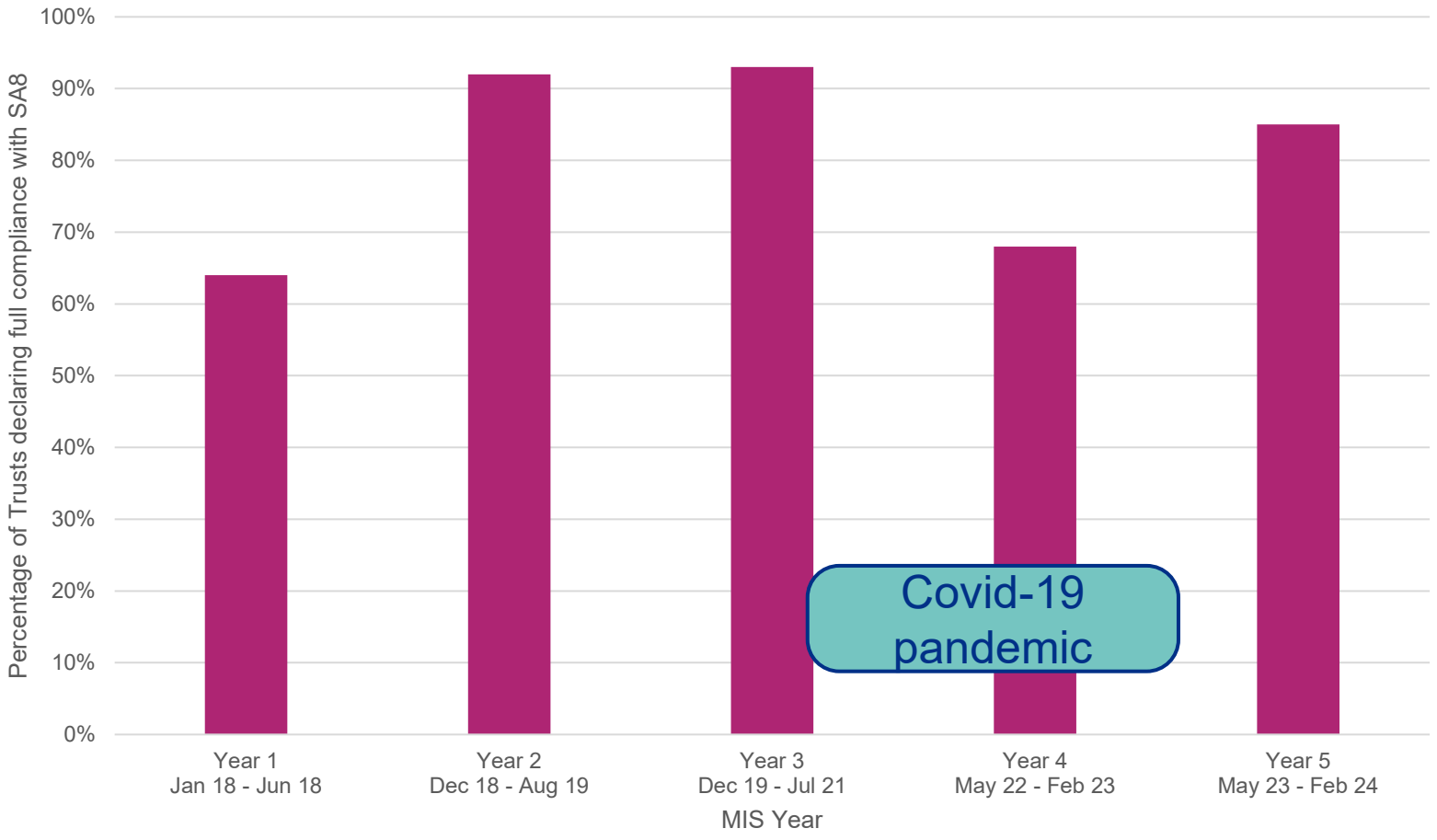
Year 5

- **PLUS**
- Quadrumvirate, Trust Board and ICB sign-off of training plan for Core Competency v2 Framework -
- Saving Babies Lives Care Bundle
- Fetal surveillance in labour
- Maternity emergencies and multi-professional training.
- Personalised care
- Care during labour and the immediate postnatal period
- Neonatal life support

Year 6

- **Return to core principles.**
- 90% attendance at 'in-house' MDT maternity emergencies training day, fetal monitoring training day,& neonatal resuscitation within year

Safety Action 8 (training) compliance



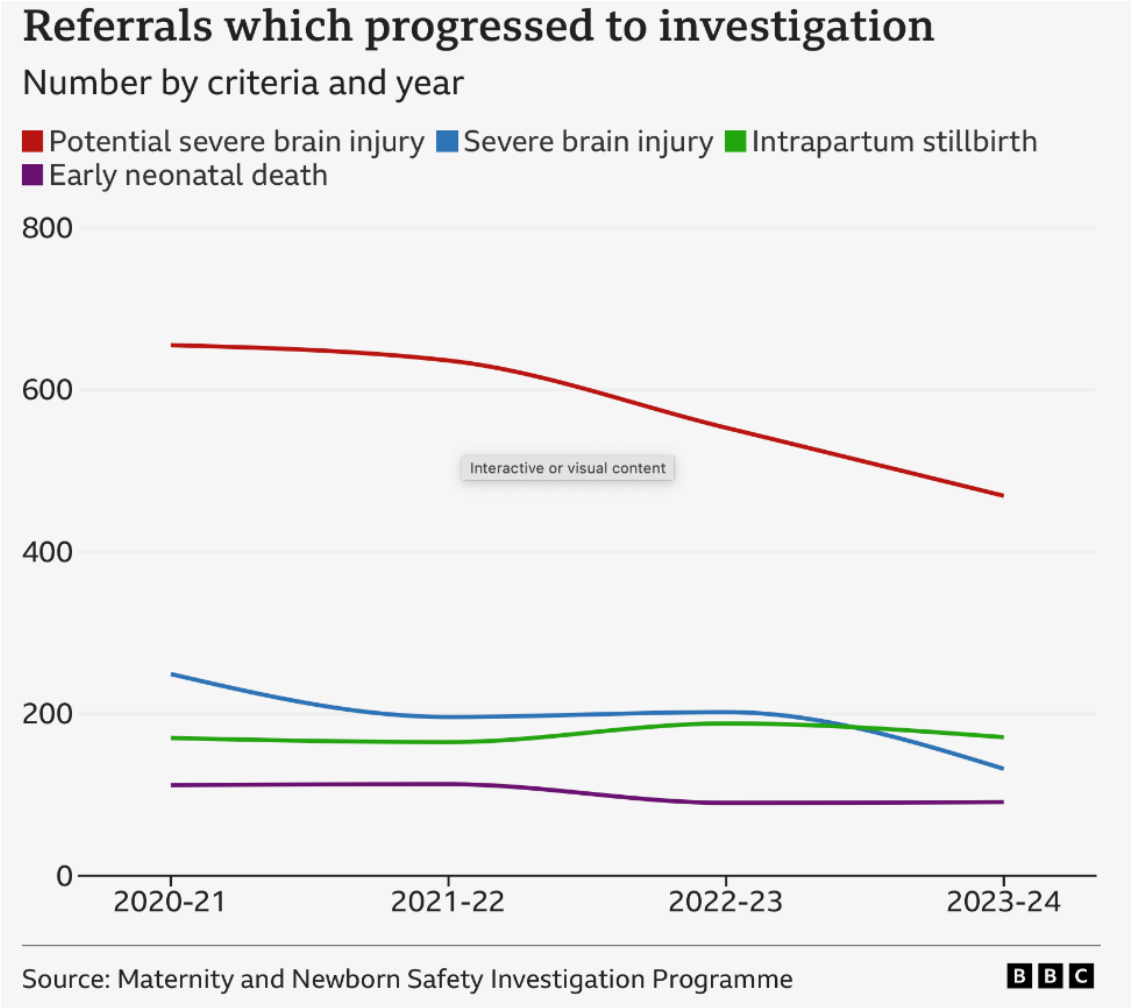
Key considerations

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

MIS Evaluation

- Challenges
  - Reporting burden
  - Complexity
- Positives
  - Raises profile of maternity within Trust
  - Cost vs value
  - Reduces variation nationally
- Independent evaluation – THIS Institute – Q3 2025

SA 8 Impact?


Referrals which progressed to investigation
Number by criteria and year
Potential severe brain injury
Severe brain injury
Intrapartum stillbirth
Early neonatal death
800
600
400
200
0
Interactive or visual content
2020-21
2021-22
2022-23
2023-24
Source: Maternity and Newborn Safety Investigation Programme
BBC

SA8 Impact

- Over 50 large-scale initiatives in maternity since 2010
- Safety landscape very crowded

ORIGINAL RESEARCH

OPEN ACCESS

Quality and reporting of large-scale improvement programmes: a review of maternity initiatives in the English NHS, 2010–2023

James McGowan ,[1] Bothaina Attal ,[1] Isla Kuhn ,[1,2] Lisa Hinton ,[3] Tim Draycott ,[4] Graham P Martin ,[1] Mary Dixon-Woods [1]

► Additional supplemental material is published online only. To view, please visit the journal online (http://dx.doi.org/10.1136/bmjqs-2023-016606).

[1]The Healthcare Improvement Studies Institute (THIS Institute), Department of Public Health

ABSTRACT

Background Large-scale improvement programmes are a frequent response to quality and safety problems in health systems globally, but have mixed impact. The extent to which they meet criteria for programme quality, particularly in relation to transparency of reporting and evaluation, is unclear.

Aim To identify large-scale improvement programmes focused on intrapartum care implemented in English

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Large-scale improvement programmes are a key strategy for addressing unwarranted variations in quality and safety of care, but their impact is mixed and often limited.

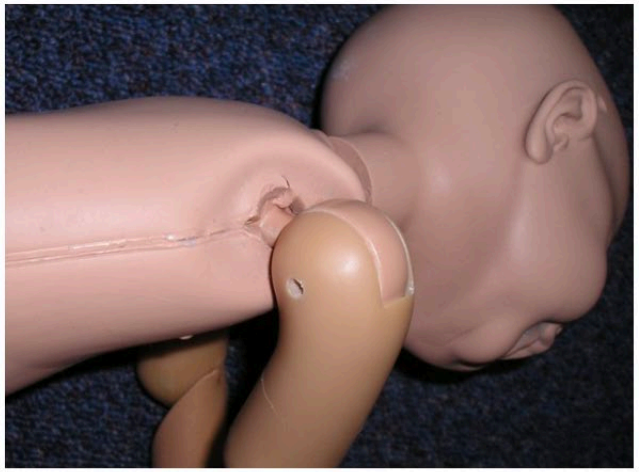
BMJ Qual Saf: first published as 10.1136/bmjqs-2023-016606 on 29 November

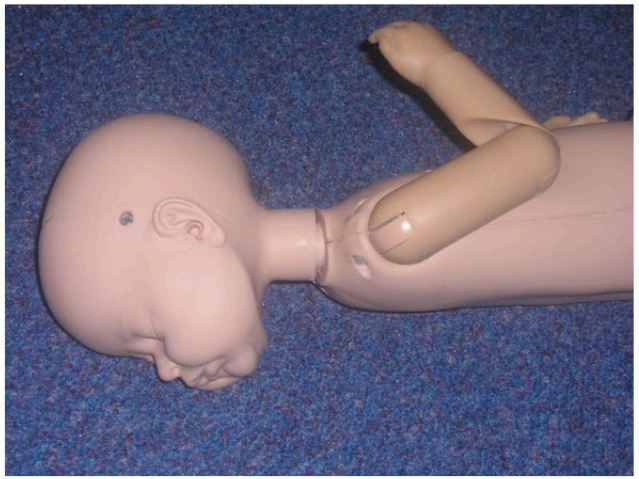
- Success has many parents …….
- SD training is only incentivised by MIS SA8

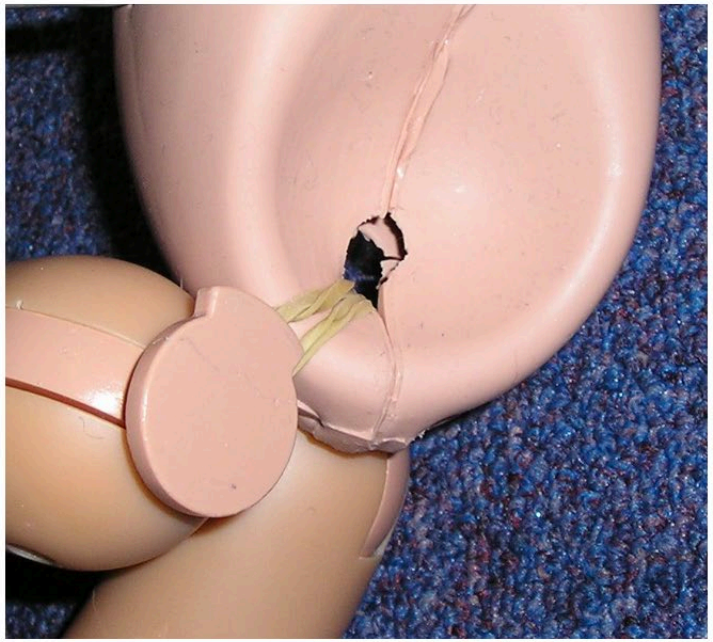
Not all SD training is equal or effective

- All international guidelines consistent for release manoeuvres
- Evidence for SD training – Pubmed Sept 2024:
  - Increase in brachial plexus injuries — 1 study
  - No change in brachial plexus injuries — 4 studies
  - Decrease in brachial plexus injuries — 9 studies
- Evidence based practice and care

Mannequin birth injuries by lawyers

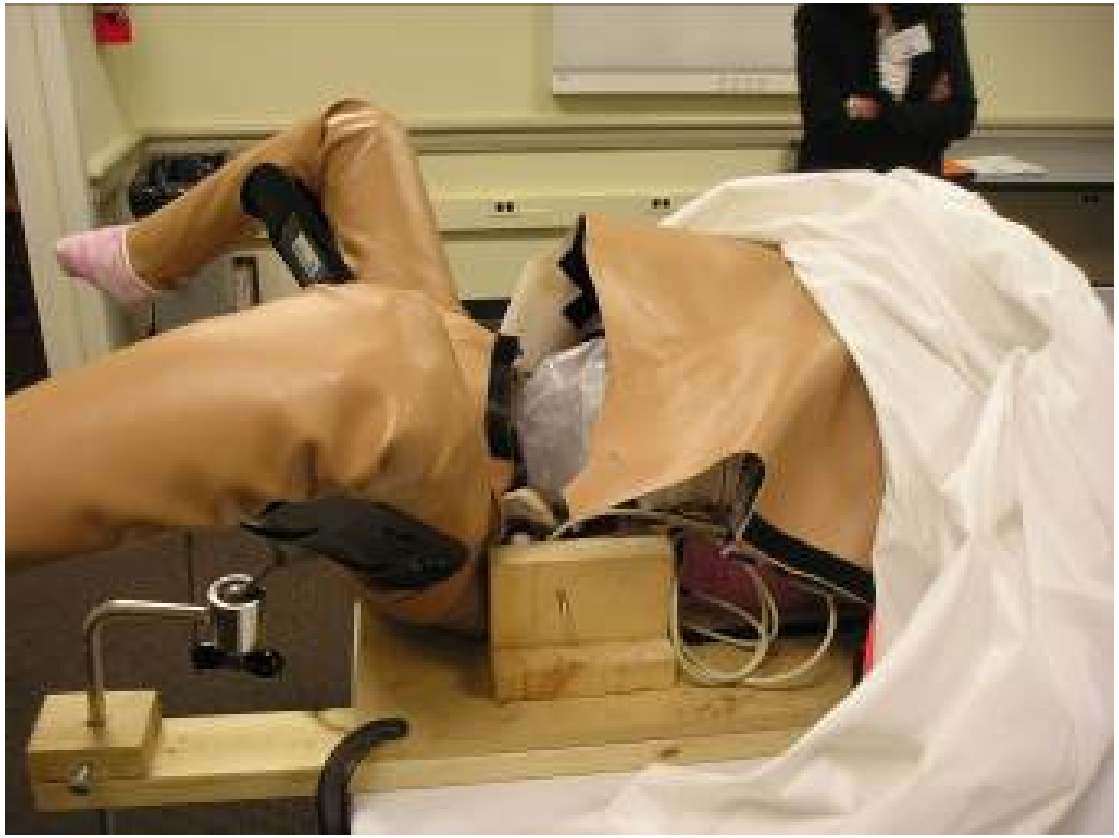


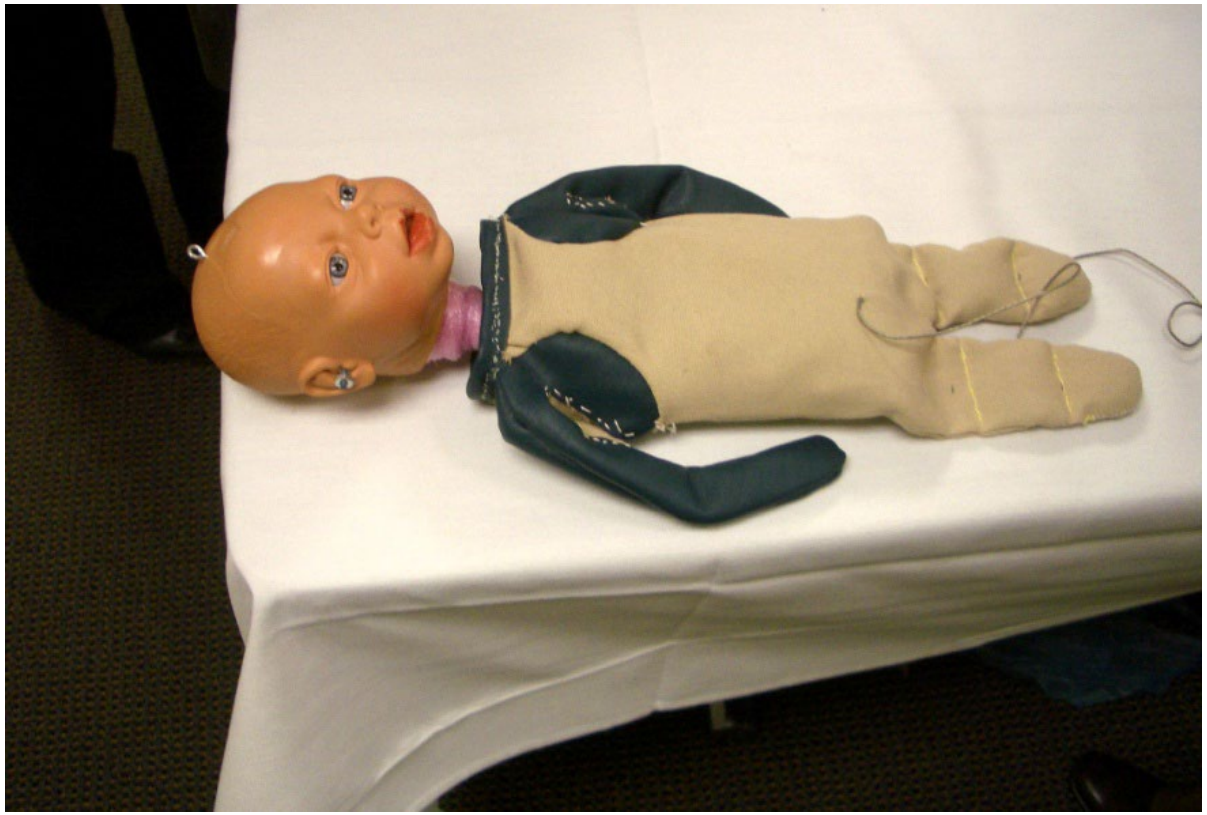




Shoulder Dystocia Training Models

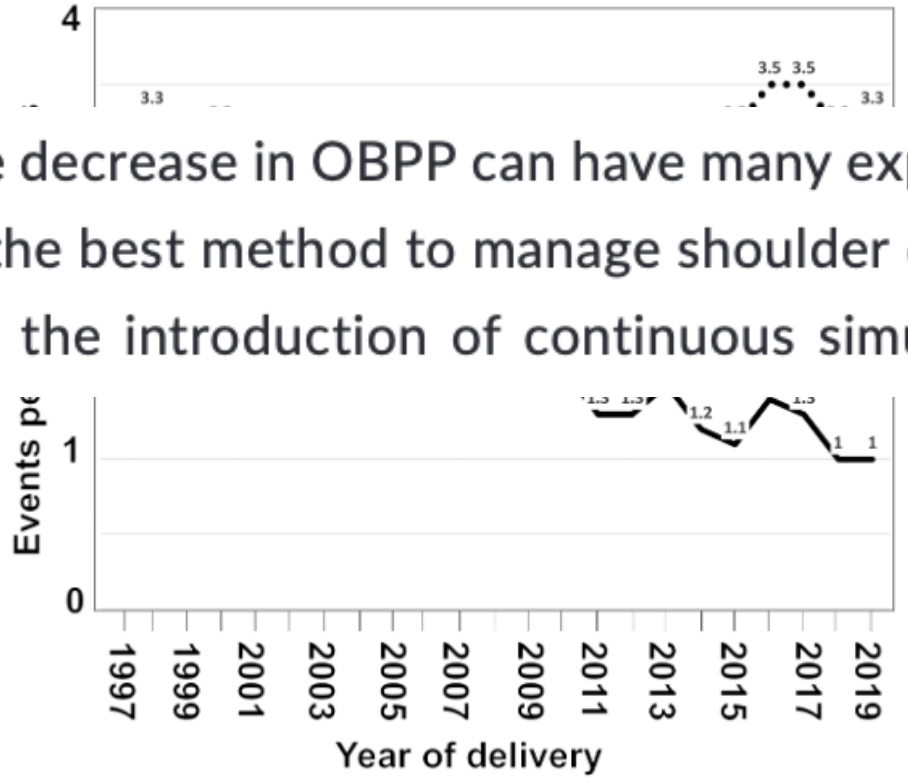
….most biofidelic model in the world ….





Training for SD can improve outcomes

- 1997 -2019 - 1.87 million vaginal births in Sweden



The decrease in OBPP can have many explanations. Knowledge about the best method to manage shoulder dystocia has grown, as well as the introduction of continuous simulation-based training.

Received: 21 August 2022 | Revised: 10 October 2022 | Accepted: 21 October 2022
DOI: 10.1111/aogs.14481

ORIGINAL RESEARCH ARTICLE

Increased incidence of shoulder dystocia but a declining incidence of obstetric brachial plexus palsy in vaginally delivered infants

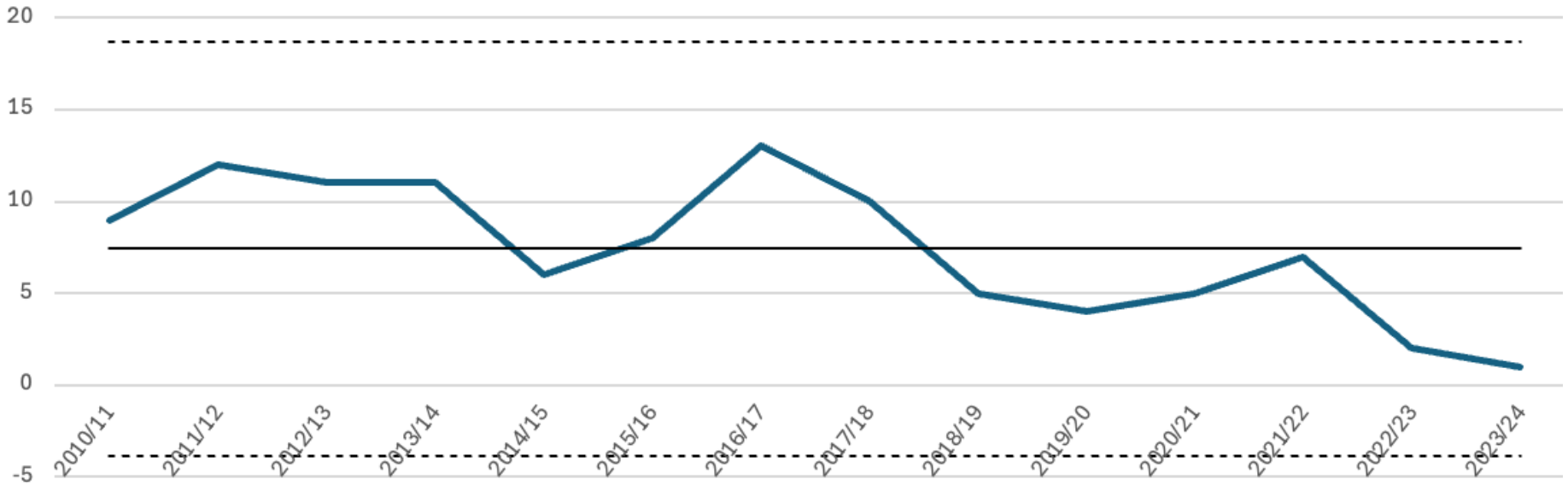
Margareta Mollberg[1] | Linnea V. Ladfors[2] | Christina Strömbeck[3] | Helen Elden[1] | Lars Ladfors[4]

Effective training for shoulder dystocia

- Published reductions in BPI post training – UK, US, NZ, Spain, Germany & Sweden
- Current evidence suggests that **effective training is**:
  - Local
  - Annual
  - Multi-professional
  - Practicing release manoeuvres on a ‘right’-fidelity mannequin
  - Using the RCOG algorithm rather than mnemonics

BPI Claims England

- Statistical Process Control plot of BPI claims England 2010 – 2024



What's next for SA 8?

- Streamline and align SA
- Recommendations to Action
- Avoiding Brain Injuries in Childbirth
  - Intrapartum fetal monitoring resources
  - Escalation resources
  - Impacted fetal head at CS resources
- Neonatal life support
  - NHSE programme to increase capacity

Restorative approaches after harm

- Compounded harm of Investigations/Reports
- Restorative justice approach
  - Jo Wailing
  - Andy Simpson
- UK Operationalisation
  - Jane O’Hara

MIS SA8 Conclusion

- Opportunity to build on solid foundations
- Cost to value
- SA8 and training associated with improved outcomes
- Listen
- Streamline and align SA8 with system

Thank you

- Liz Pilling – Consultant Neonatologist
- NHS Resolution Maternity Incentivisation team
  - Bridget Dack
  - Selina Dubison
- NHS Resolution Safety & Learning team
- All of you

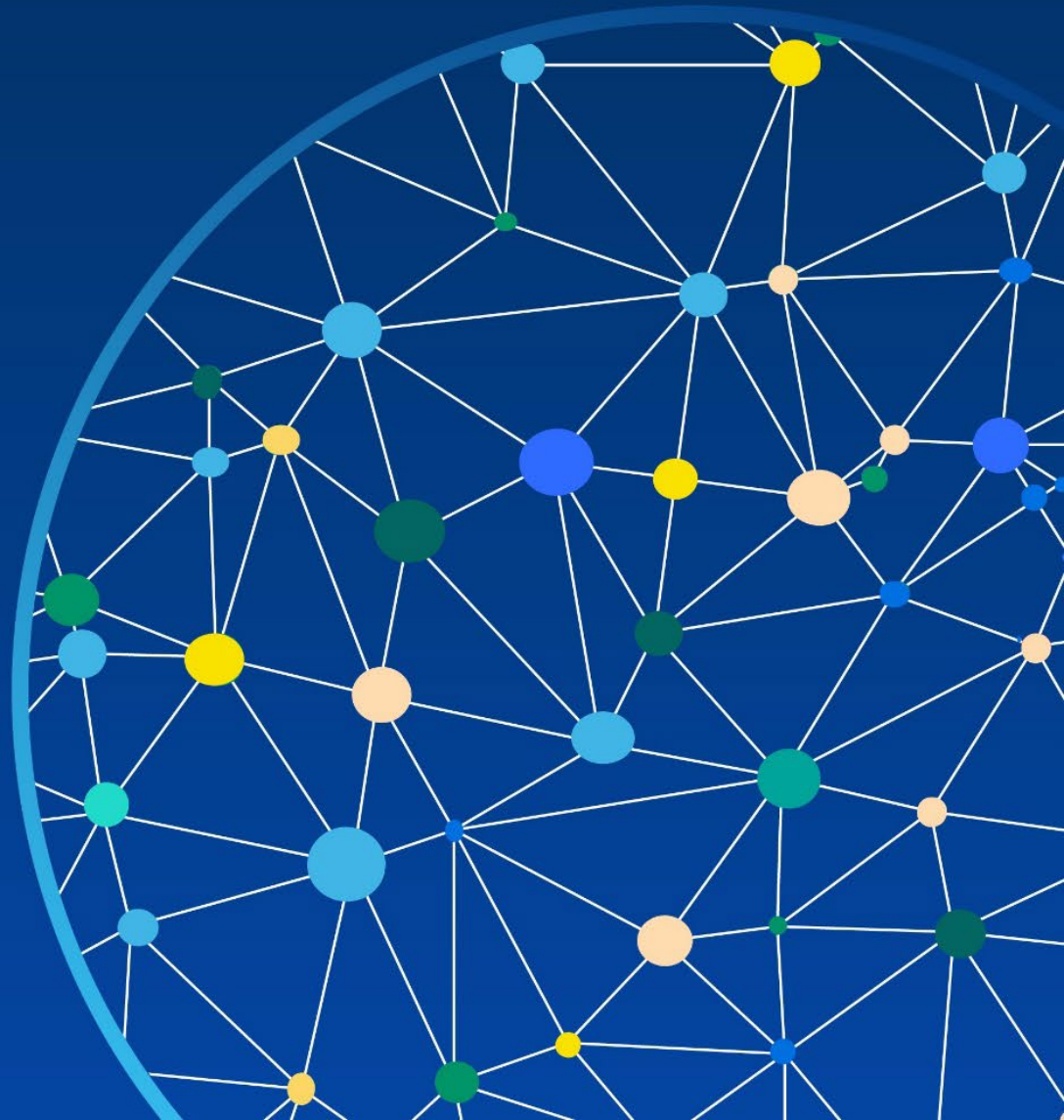
NHS Resolution

Practitioner Performance Advice

Maternity Team Reviews

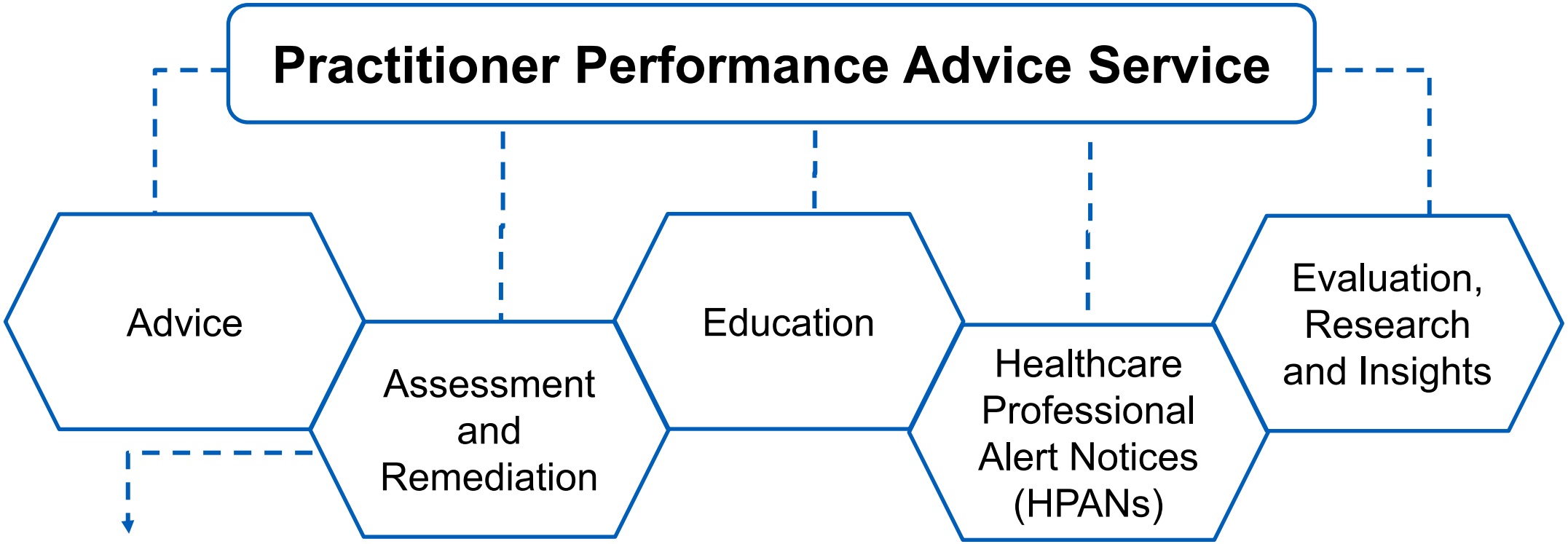
Neil Armstrong
Casework Systems and Guidance Manager

Caroline Latham-Parker
Safety & Learning Lead – South



Advise / Resolve / Learn

How we support resolution of concerns



Assisted mediation
Behavioural assessments
Clinical performance assessments
Professional support and remediation
Team reviews

https://resolution.nhs.uk/services/practitioner-performance-advice/

Assessment and remediation

Our assessments help to clarify and understand the performance of individual practitioners (doctors, dentists and pharmacists), and provide the healthcare organisation and practitioner with a sound basis upon which to bring the case towards a resolution.

- Behavioural assessment
- Clinical performance assessment
- Professional support and remediation
- Assisted mediation
- Team reviews/**maternity team reviews**

**there are charges applicable to some assessment and remediation services*

Maternity team reviews – why?

- The culture in a maternity service is directly related to the quality and outcomes of the service. Maternity service reviews have found evidence of team dysfunction, across different professional groups.
- Importance of the role of the multidisciplinary team and working relationships between team members
- To help provide a better understanding of the barriers to resolving behavioural issues within a maternity team and to suggest options for improving professional relationships.
- The maternity team review is designed to play a valuable role in helping to address some of the factors that impact maternity performance in England.

Maternity team reviews – how?

- Can cover a multidisciplinary team, including obstetricians and midwives, but also, and not exclusively, obstetric anaesthetists, neonatologists and maternity support workers.
- It is not a service review nor an investigation but seeks through questionnaires and semi structured interviews with team members to understand their views on how the team functions and what the issues in the team may be

- An outcome report which sets out diagnosis as well as recommendations to support a robust management plan and ongoing follow up support and monitoring to help facilitate sustained change

Further information

For more information on maternity team reviews and to read a case study, visit our webpage:

Maternity team reviews - NHS Resolution

To discuss further, please contact:

Rineke Schram, FRCOG, Lead Assessment and Remediation Adviser
rineke.schram@nhs.net

Advice team

nhsr.Advice@nhs.net

Maternity (Perinatal) Incentive Scheme - Safety Action 10 and case story

Annette Anderson – Head of Early Notification Clinical (NHS Resolution)
Sandy Lewis – Director, Maternity and Newborn Safety (MNSI)
Sangita Bodalia – Head of Early Notification Legal (NHS Resolution)

@NHSResolution

Session outline

1. Reporting requirements and what is new for MIS year 7
2. What is working well and common areas we feedback on
3. Useful resources to support you in your work
4. Illustrative Case story
5. Good practice points for the liability investigation stage

! This does not cover reporting through SPEN (submit perinatal event notification)

Aims of both programmes

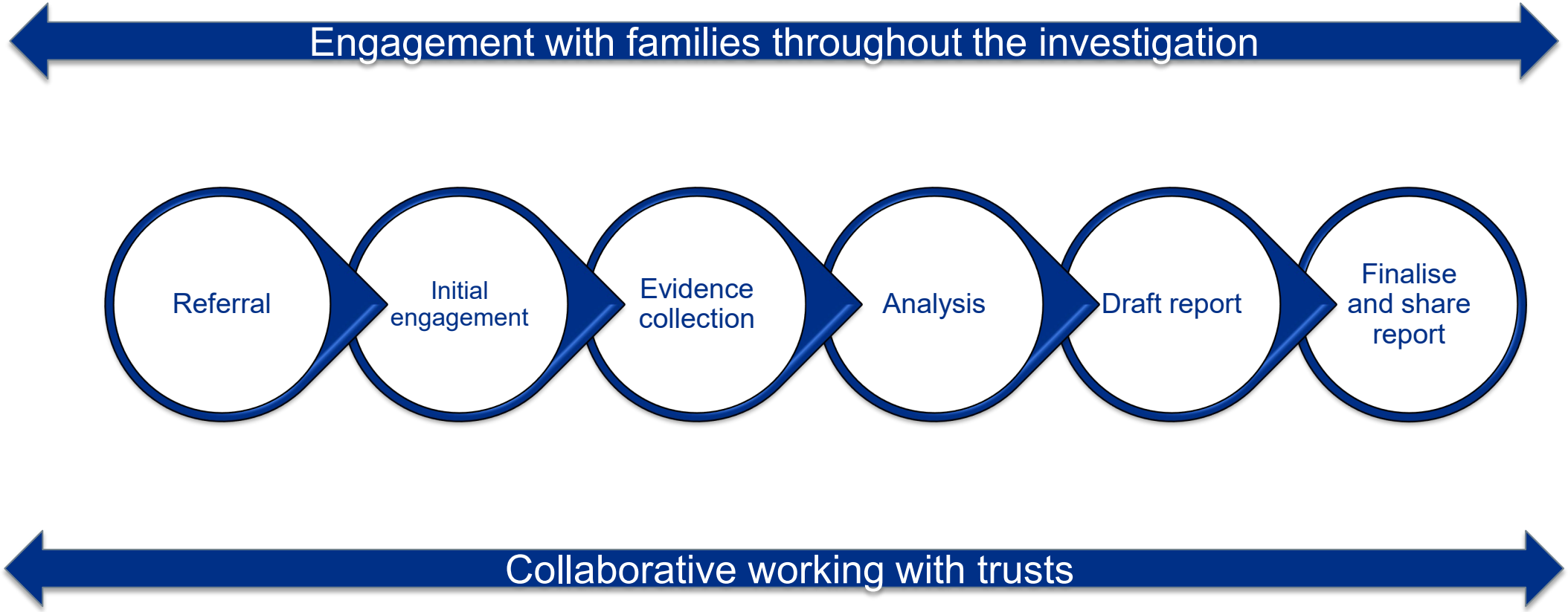
MNSI

- To provide independent, standardised and family focused investigations of maternity cases for families
- To provide learning to the health system via reports at local, regional and national level
- To analyse data to identify key trends and provide system wide learning; be a system expert in standards for maternity investigations and to collaborate with system partners to escalate safety concerns
- What we investigate can be found here: https://www.mnsi.org.uk/our-investigations/what-we-investigate/

Early Notification Scheme

- Investigate potential eligibility for compensation and improve the experience for the family
- Improve the process for obtaining compensation for families, meeting needs in real time where possible
- Share learning rapidly with the individual trust and the wider system

Maternity investigation approach



Key areas during MNSI investigation process

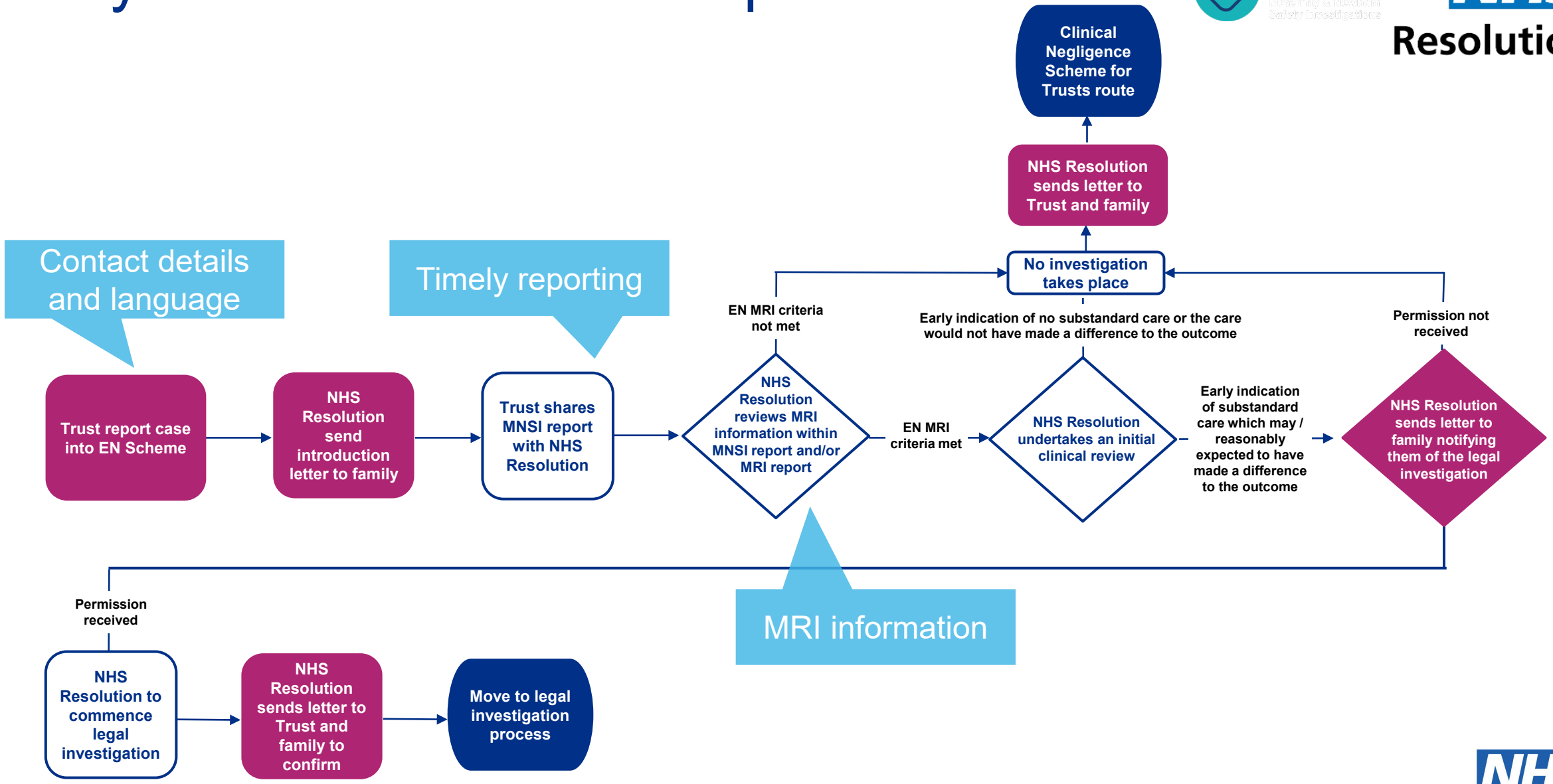
- Immediate review / Duty of Candour
- Consent to share details – sharing of medical notes
- Family contact made – Family Inclusivity Tool (FIT) assessment completed
- For severe brain injuries all events are reviewed through a triage process – to confirm harm (MRI is required) /trust or family concerns
- Investigation process commences – approximately 6 months
- Any concerns identified during an investigation are shared whilst the investigation is ongoing
- Completion of factual accuracy/ finalise report /tripartite meeting

New for MIS year 7

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

- the family have received information on the role of MNSI and NHS Resolution's Early Notification Scheme in a format that is accessible to them; and
- 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.

Early Notification Scheme process



What is working well?

- Good reporting
- Trust engagement with processes – queries
- Responsive to queries for external verification

Common feedback areas to trusts

- Governance and reporting to Board
- Not being clear whether duty of candour has started or not
- Delays in sending in MNSI reports to NHS Resolution

MNSI resources for families

The below shows you all the family engagement resources available to assist families. The links can be accessed by clicking on the underlined text.

Index of FE resources	Introductory card	Family information summary	Family information (full)	Feedback and terms of reference letter (now in HIMS)
Letters for Families who have not engaged	Post May 2024 sample report	Letter to be sent with final report	Factual accuracy form for families	When an investigation has finished
Tripartite meetings	Request for feedback postcard	Investigation process (10 steps)	Letter to be sent with draft report	Family feedback form

NHS Resolution resources for families

The links can be accessed by clicking on the underlined text.

Early Notification web page	Dedicated Family Liaison team	FAQs for families or carers	Early Notification animation for families	Language repository
Persian (Farsi)	Arabic	Bengali	Hindi	Ukranian
Urdu	Romanian	Polish	Somali	Punjabi

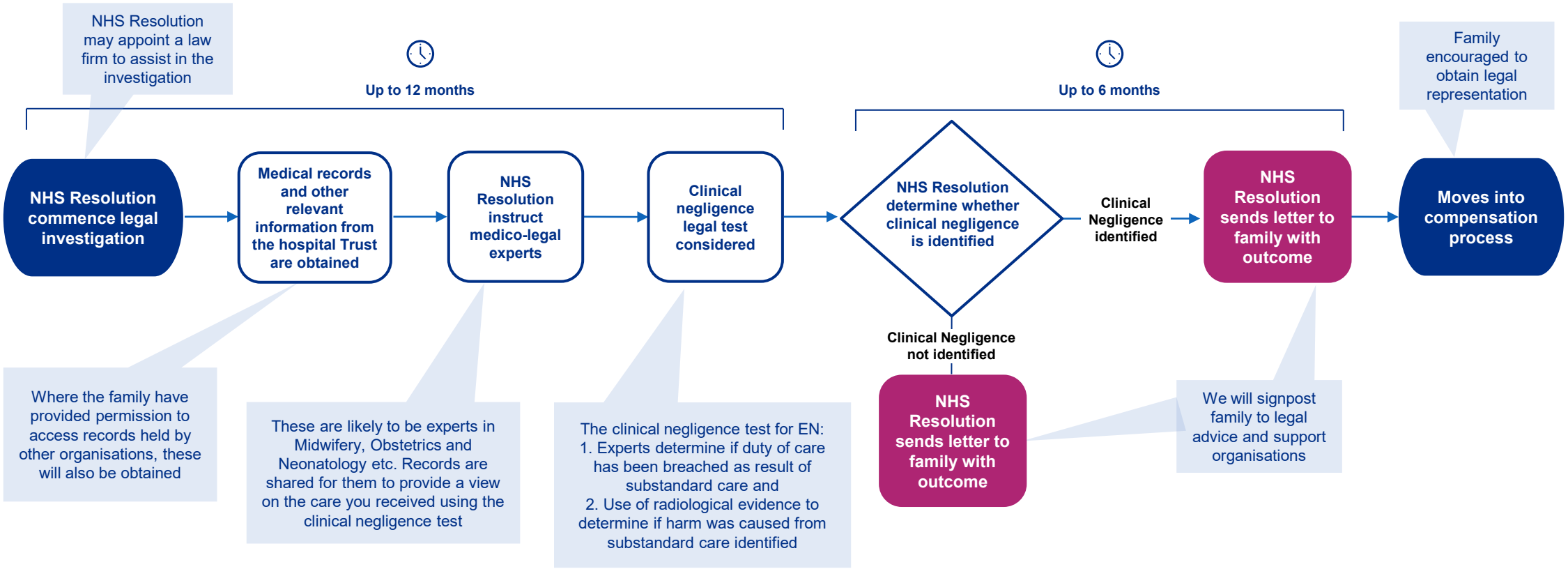
Case story

Mrs K had an emergency caesarean section due to a placental abruption; she had been in established labour and was 7cm when it occurred

Her baby was born in poor condition requiring extensive resuscitation

MRI scan on day 7 indicated an acute profound hypoxic injury and the baby has significant ongoing care needs.

Early Notification Scheme Legal investigation process



Please note, the investigation make take longer depending on a number of factors. Family/representatives will be updated during the investigation.

Compensation Process

- Quantum assessment – will include review of care, therapies, accommodation etc.
- NHS Resolution would seek strategies and solutions to reduce time and cost
- Similar case - settled for a lump sum of £7.5m, with payments every year for the child's life for care and case management of circa £250,000 pa
- The total cost (capitalised sum) of these claims can be over £20m

Benefits of the Early Notification Process/ Good Practice

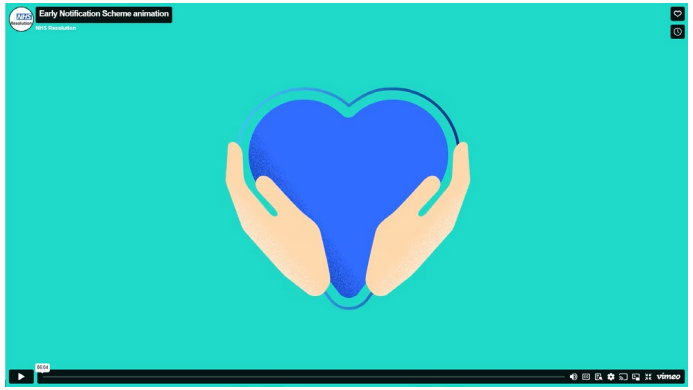
- Good working relationships – clinical involvement is key!
- Family engagement process direct contact from NHS Resolution
- Timely response on requests for documentation – medical records, approvals to letters etc.
- Early admissions and apology for family plus early interim payments
- Joint expert evidence - reduces legal spend
- Early settlement meetings

Learning Resources

Early Notification web pages

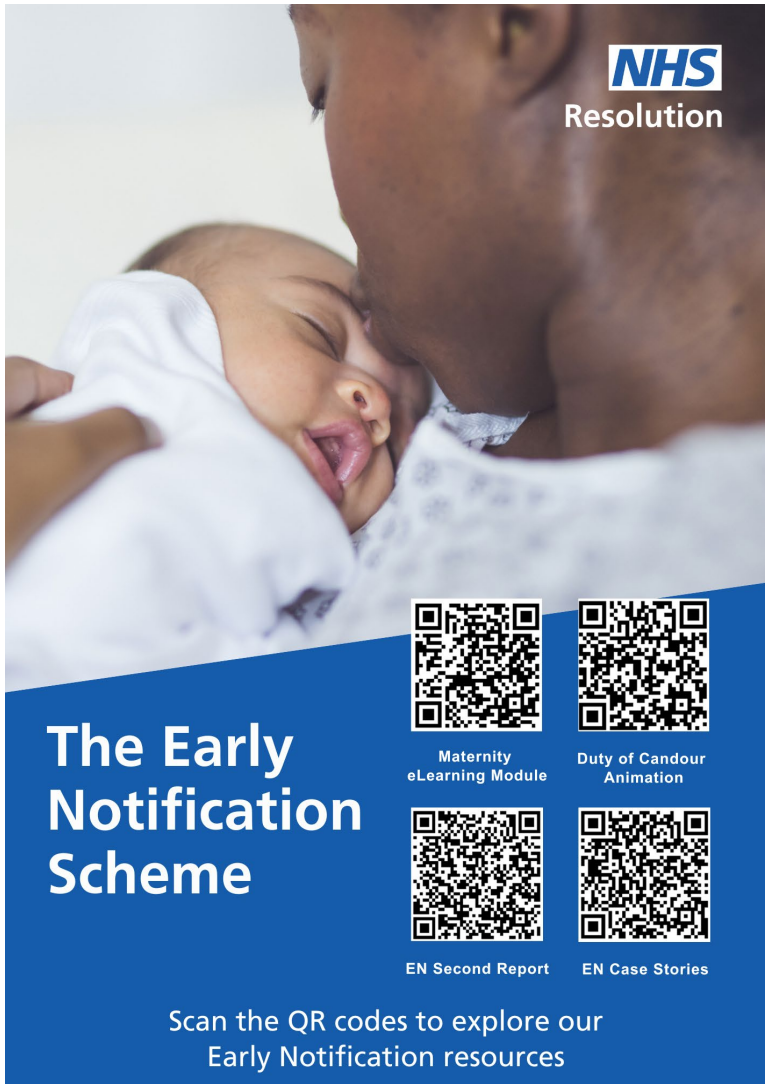
- Early Notification landing page (www.resolution.nhs.uk - search "Early Notification")

EN animation for families



EN eLearning module (also available via NHS England and RCOG/RCM)
eLearning module - focuses on learning from the significant avoidable harm that can occur during the antenatal, intrapartum and postnatal care of mothers and their babies and seen in the cases notified to its Early Notification Scheme.

EN case stories
EN case stories are illustrative and based on recurring themes from real life events. These experiences have been highlighted and shared to help identify potential risks in your clinical area, promote learning and prevent fewer incidents occurring in the future.



Family resources

You can access the EN Family web pages by scanning the QR code below or by typing the website address below into your web browser

https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/early-notification-scheme/support-for-patients-families-or-carers/

You can access our advice for claimants web pages by scanning the QR code below or by typing the website address below into your web browser.

https://resolution.nhs.uk/services/claims-management/advice-for-claimants/

You can access the ‘Introduction to clinical negligence claims’ video by scanning the QR code below or by typing the website address below into your web browser.

https://youtu.be/98RYE0NIlVk

Family resources

You can access the AvMA guidance to help with calculating the time limit for making a claim by scanning the QR code below or by typing the website address below into your web browser.

https://www.avma.org.uk/wp-content/uploads/Legal-time-limits.pdf

You can find more information about clinical negligence claims by scanning the ‘Introduction to clinical negligence claims’ QR code below, or by typing the website address below into your web browser.

https://youtu.be/98RYE0NIlVk

Thank you for joining us!

NHS Resolution

Rebecca Wilson-Crellin, Deputy Director for Maternity Programmes & Evaluations, NHS Resolution

Becky joined NHS Resolution in September 2024 as the Deputy Director of Maternity Programmes and Evaluations.

She qualified as a midwife over 20 years ago. She has worked in a national role since 2017, having previously been a senior clinical advisor to NHS Resolution's early notification scheme, and the clinical lead for maternity and neonates in the national patient safety team at NHS England. She went on to work as the clinical lead for culture and leadership in the national maternity and neonatal programme team at NHS England, where she led the perinatal culture and leadership programme which was designed to support perinatal leadership teams across England to create and craft the conditions for a positive culture of safety and continuous improvement.