NHS Resolution

Maternity incentive scheme – an interim evaluation

Advise / Resolve / Learn

Contents

An interim evaluation

Maternity safety is an important issue for all members of our Clinical Negligence Scheme for Trusts (CNST) and for those who receive their services. Obstetric incidents can be catastrophic and life-changing, with related claims representing the scheme's biggest area of spend. The cost of clinical negligence incidents occurring within the 2018/19 year for secondary care in England reported under our CNST was £9 billion – of which maternity represented 60%. Currently over £1,100 is spent on indemnity costs for every baby born in England. Annually obstetric claims represent around 10% of the volume and 50% of the value of all clinical negligence claims notified to us.

For a third year we have joined forces with the national maternity safety champions, Dr Matthew Jolly and Professor Jacqueline Dunkley-Bent OBE, to support the delivery of safer maternity care through an incentive element to the contribution to the CNST, rewarding trusts meeting ten safety actions designed to support the delivery of best practice in maternity and neonatal services. This report represents an interim evaluation of the impact of the scheme to date.

Summary

NHS Resolution's maternity incentive scheme (MIS) is delivering demonstrable progress by driving compliance with ten essential safety actions (Appendix A) which support the safety workstream of the national Maternity Transformation Programme. It has cross-system support from the National Maternity Champions, Care Quality Commission (CQC), NHS England and NHS Improvement, the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) and importantly, providers who are driving improvements in maternity care. The actions are owned by these bodies who are members of NHS Resolution's Collaborative Advisory Group (CAG) which advises on the scheme's development.

The scheme has been delivered by NHS Resolution and its CAG, as it was designed, with a process of self-certification. This is aligned with Board governance responsibilities for their annual report and accounts. It is recognised that recent examples of poor governance from trusts in relation to the certification of submissions require further action.

Trusts who demonstrate full compliance with the scheme's ten safety actions recover their element of CNST contribution that went into the maternity incentive fund, plus a share of any unallocated funds. Trusts who do not meet all ten actions are able to recover a lesser sum from the fund to help them achieve the outstanding actions if they are able to demonstrate a robust business case for improvement.

Trusts self-certify their compliance with the ten actions. Trust submissions are required to be signed off by the trust chief executive and trust Board and should be discussed with commissioners prior to sign off. Trust submissions are subject to external validation by NHS Resolution on three of the ten actions and sense-checked with the CQC before the results are finalised.

In year one (2018), 75 out of 132 (57%) trusts certified as achieving all ten actions. The ten actions remained the same in year two but with added stretch in the required standard of compliance (see Annex A for the ten actions).

The results for year two show that 117 out of 130 trusts (90%) certified as having achieved all ten safety actions, which represents a significant uplift on the year one position. (The total number of maternity trusts has reduced from year one due to mergers.)

The MIS is monitored on an annual basis and a full evaluation is expected to take place after three to four years of operation since this is the earliest we could expect to see a reduction in the number of brain injuries at birth reported to NHS Resolution's Early Notification scheme (ENS) turning into legal claims. While it may be challenging to isolate the quantitative impact of the MIS from other maternity initiatives, the scheme has had demonstrable success in driving improvements and feedback from participating trusts indicates that it has given greater prominence to the actions required to increase maternity safety at Board level with the following benefits highlighted by providers, in particular:

a. Improvement in safety culture
b. Improvement in trust Board engagement in maternity issues
c. Additional funding to recruit to key clinical posts within maternity
d. Greater influence for multi-disciplinary working, e.g. across anaesthetic and neonatal services.

Trusts which have failed to achieve all ten actions have been offered tailored support from the Chief Midwifery Officer's team in NHS England and NHS Improvement to assist them in achieving full compliance in year three. The team will also work with NHS Resolution to deliver workshops to drive improvement in maternity services in these trusts.

The final results for both year one and year two of the CNST MIS are published and can viewed on NHS Resolution's web site.

Year two of the MIS in detail

Year two of the MIS was run between December 2018 and August 2019. In August 2019, NHS Resolution asked trusts to participate in an evaluation survey to provide feedback on their experiences of the second year of MIS and meeting the requirements of the 10 safety actions. The survey invited ranked responses to some of its questions but also sought narrative comments to provide feedback on the scheme.

The survey responses were positive about improved learning and safety within trusts as a result of engaging in the scheme.

Headlines

Over 86% of the trusts reported that as a result of engagement in MIS there had been improved communication between boards and maternity services, which had resulted in increased support for the implementation of all safety actions.

Feedback from maternity trusts demonstrate that the scheme is making a positive and sustainable impact on the delivery of safer maternity care, with the following benefits highlighted in particular:

a. Improvement in safety culture
b. Improvement in trust Board engagement in maternity issues
c. Additional funding to recruit to key clinical posts within maternity
d. Greater influence for multi-disciplinary working, e.g. across anaesthetic and neonatal services.

Improvement in safety culture

Trusts report that Maternity Voices feedback (safety action 7), staff listening events and the use of midwifery and clinical workforce (safety actions 4 and 5) allowed them to agree uplifts in midwifery staffing.

One trust stated that prior to the introduction of the MIS some maternity safety issues were not previously explored as they were either not mandated or due to resistance from members of staff. The scheme has enabled trusts to review these issues. For example, getting theatre staff involved in multidisciplinary training (safety action 8) was a significant challenge, whereas the scheme made this essential.

Improvement in trust Board engagement in maternity issues

Trusts have stated that the scheme has ensured maternity services are treated as high priority and the role of the Board level safety champion (safety action 9) positively improved this. Also, it is helping trusts to ensure that areas that they are finding difficult remain high on their agendas.

This scheme has developed better engagement with the trust Board and the executive teams. There is a strong link with Quality Improvement and finance which is being demonstrated through a number of the safety actions.

Improvements arising from funding and staff appointments

Trusts have stated that the MIS has enabled them to make staff appointments, such as quality and safety programme leads, which will help them in achieving higher levels of quality and safety.

One trust reported that having funding to make improvements within the service in times of financial constraint has allowed a centralised fetal monitoring system to be purchased when this had been declined for many years due to cost implications. Staffing for neonatal transitional care was also funded from the year one incentive funds received.

Greater influence for multi-disciplinary working, e.g. across anaesthetic and neonatal services

Trusts have stated that alignment of safety actions with national programmes has enhanced maternity team understanding of the safety landscape within maternity and neonatal services for provider organisations. Working towards the objectives and the reporting timetable has enhanced multi-professional and interdivisional working.

Trusts reported that there have been developments within maternity services since the MIS was launched with trust (staff and Board) and clinical commissioning groups (CCG) engagement. This has improved the maternity pathways for women during antenatal, intrapartum and postnatal care. For example, risk assessment and surveillance of fetal growth restriction and reducing smoking in pregnancy.

Which maternity safety actions do trusts believe will have a positive and sustainable impact on their ability to deliver safer maternity care?

Trusts responded that staff training, midwifery workforce planning and engaging with the Saving Babies Lives care bundle were considered most likely to have a significant positive impact. The graph on page 8 reflects feedback from trusts.

Safety action 7: Multi-disciplinary training (MDT)

Trusts felt that safety action 8 (in-house multidisciplinary training) was particularly useful when preparing for an emergency that required a surgical intervention. One reported how well-rehearsed team working had a positive impact on the effective management of post-partum haemorrhage. MDT training is proven to enhance safety and is particularly important when human factors are taken into consideration.

Safety action 6: Saving Babies Lives

Trusts felt that by ensuring staffing levels are appropriate will have a positive impact on patient safety, as will implementing evidence based care bundles. There is evidence that Saving Babies Lives has had a positive effect on the safety of mother and baby.

''Saving babies lives bundle have made us review how we use our resources and we have seen improvements in outcomes.''

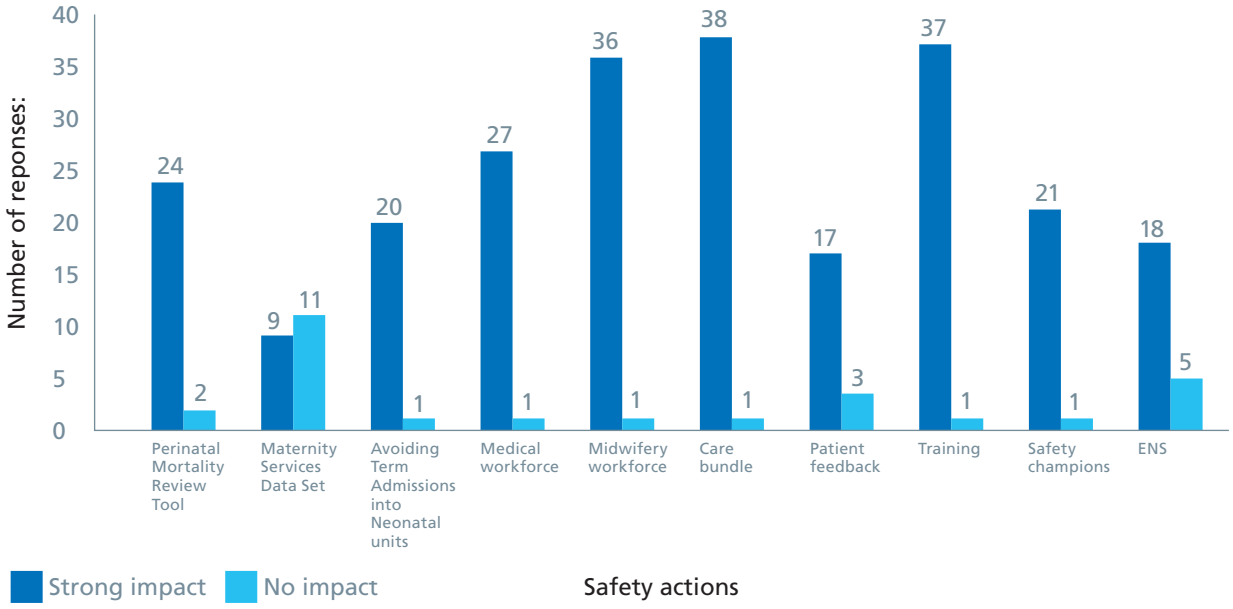
''Implementing this will have the most tangible benefit – does demonstrate issue around scan capacity.''

Safety action 3: Avoiding Term Admissions Into Neonatal units Programme (ATAIN)

This enhances patient experience and reduces the anxiety mothers have when separated from their infants. It also improves communication between maternity and neonatal teams therefore improving patient safety.

''Transitional care is really supporting mums and babies staying together. Looking at the themes to avoid term admissions can improve safety."

Maternity safety actions with a positive and sustainable impact on delivery of safer maternity care



Which maternity safety actions were the most challenging to meet and why?

It was recognised that safety action 8, Training, was one of the most important actions for maternity safety. However, it was also considered to be the most challenging to achieve.

The trusts that reported difficulties in achieving safety action 8 explained that problems included resourcing issues and difficulties related to managing and engaging staff particularly where they are based over multiple sites and across different trust divisions. The graph below reflects feedback from trusts.

Examples of the feedback received are as follows:

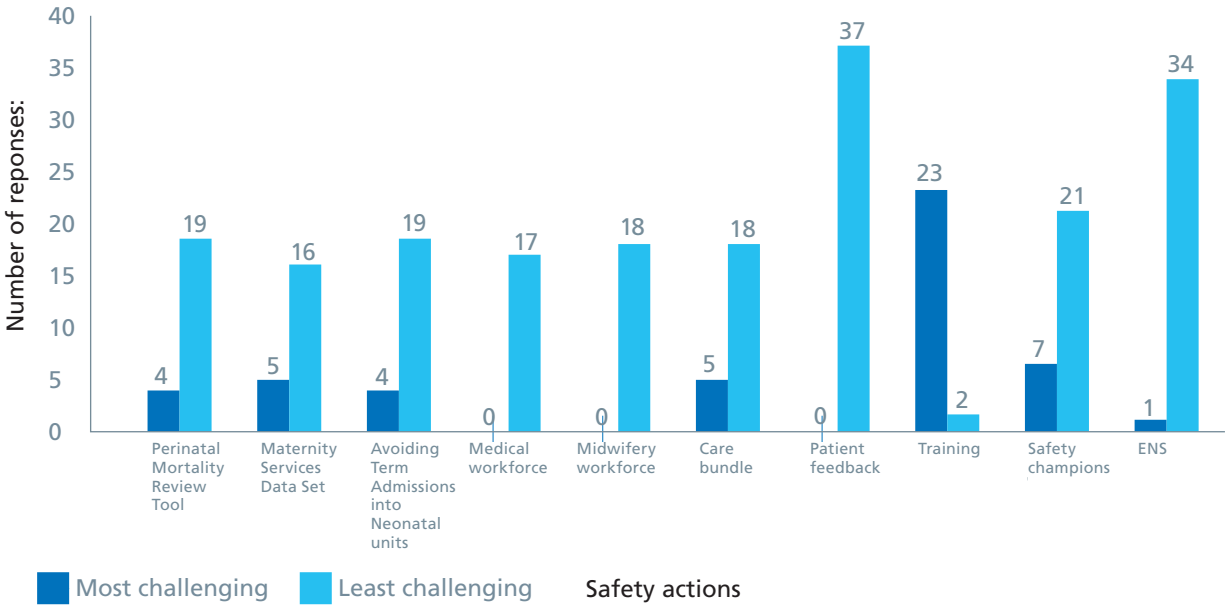
Resourcing to support training

- *"Providing enough spaces on study days for all staff from the MDT and releasing them from clinical duties to attend was a huge challenge."*
- *"Need to facilitate additional training sessions to accommodate all numbers. Challenges with trainers medical and anaesthetics being released from clinical commitments – competing priorities with abundance of Statutory and Mandatory training also. Releasing staff to attend training in high acuity."*

Managing and engaging staff

- *"The requirement for all staff working in maternity (including ODP and Recovery staff) does pose a problem when we don't run our own theatres. Maternity Theatres although in our department are staffed by Theatres Central Team. We have rotational Anaesthetic staff too."*
- *"The training standard was the hardest as there are so many demands on staff time, and it was difficult to obtain engagement in non-obstetrics groups in a short space of time without additional resource to achieve it."*
- *"Multi-disciplinary training to include Anaesthetic staff has been very challenging but a programme of drills have been put in place and attendance monitored."*
- *"Enabling attendance of staff such as theatres and anaesthetists is challenging as these teams vary in size in organisations and often sit in other divisions."*

The safety actions which were the most challenging and the least challenging



Challenges faced in meeting other safety actions

The survey results show that trusts faced a number of challenges in meeting other safety actions. Key issues surrounded a requirement for greater clarity of drafting of the safety action requirements, IT issues, staff resourcing (particularly with regard to the PMRT) and difficulties in coordinating MIS deadlines with trust Board meetings. Some of the comments illustrating the challenges faced by trusts are set out below:

Greater clarity in drafting safety action requirements

The main challenge relates to the way the safety action requirements were drafted which caused confusion in terms of what was needed and in relation to timelines. This was particularly felt in relation to safety action 9 'Safety Champions' described as complex and confusing, and safety action 6 'Care Bundle' which led to trusts debating what compliance meant and what evidence was required.

The technical guidance provided for each action also created confusion as they were perceived to conflict with the accompanying safety action requirements.

IT issues

There were challenges with Maternity Services Data Set (MSDS) data and system suppliers, with some not being pro-active in supporting the trusts following systems upgrades. It was felt that NHS Digital could encourage suppliers of digital services to maintain high levels of support and development throughout contracts to ensure systems are up to date and work as expected.

Resourcing issues (PMRT tool)

A number of trusts also reported difficulties in compliance with safety action 1 as a result of delays in receiving post mortem and placental histology results within the required timeframe. It was felt that the PMRT tool was resource intensive, both in relation to time taken to complete reports, reliance on cross-system data and duplication of existing systems (Datix). Additionally, the format of the report created additional work as it could not be shared with families.

Coordination of MIS deadlines and trust Board meetings

Trusts reported difficulty coordinating MIS deadlines with Board meetings and consider that having a wider timeframe would assist with the formal reporting requirements. safety action 9 ('Safety Champions') led to re-scheduling of arranged meetings between Board members and clinical safety champions.

NHS Resolution, in conjunction with the maternity incentive scheme safety action leads, and in response to the survey findings, have strengthened the technical guidance within each of the ten safety actions, in particular for PMRT. In addition, the requirements of the PMRT safety action have not been changed for year three of the maternity incentive scheme.

Key deadlines have been included within each of the safety actions for year three, and this allows trusts greater flexibility with scheduling key meetings for the maternity safety actions to be reviewed and discussed. For year two, NHS Digital worked closely with trusts to support and guide them through the system challenges with reporting data. Following the launch of year three of the scheme, a successful webinar was hosted by NHS Resolution, NHS England and NHS Improvement with support from individual safety action leads. As well as being able to submit queries to the dedicated maternity incentive scheme inbox, the webinar provided trusts with the opportunity to have their questions answered earlier, especially in relation to maternity safety champions and version two of the saving babies lives care bundle.

Trust self-certification

Trust self-assessments are subject to verification against three external sources of validation and checked with the CQC. If any concerns or anomalies are identified, these are investigated and, if required, further evidence is requested from the trust. Final decisions on the scheme results are made by NHS Resolution. This is an ongoing process and if any issue arises at any time which calls the certification by a trust into question, this will be investigated by NHS Resolution, supported by its CAG.

Once trust submissions are received by NHS Resolution, they are reviewed to ensure signature by the trust chief executive on behalf of the Board declaring that the submission has been discussed with the local commissioner. In addition, all action plans for all trusts who have not met all 10 safety actions are reviewed by a member of the clinical team and the review includes checks that the action plan has clinical and executive support and SMART deliverables.

Submissions then follow a three-point external verification process which enables NHS Resolution to challenge them where appropriate. These are:

- The use of the National Perinatal Mortality Review Tool is verified with MBRRACE-UK. Following verification in 2019, 35 trusts were required to submit further evidence and one trust subsequently failed this check;
- The submission of data to the Maternity Services Data Set is ratified with NHS Digital;
- Full reporting of qualifying incidents to NHS Resolution's Early Notification scheme is cross-checked with the National Neonatal Research Database.

All submissions declaring full compliance are discussed with the CQC and if concerns are highlighted, trusts are asked to review and confirm their submission.

The final results are confirmed and ratified by NHS Resolution's approvals committee which includes a non-executive member of NHS Resolution's board.

Should concerns emerge either during or after confirmation of the results, trusts are asked to review their submission and, if required, submit supporting evidence to NHS Resolution. If a trust is subsequently found to not be compliant, they will be required to repay any funding received and asked to review submissions from previous years.

Concerns raised by NHS Resolution in line with this process identified a small number of trusts whose certification had to be challenged and in some cases, rescinded. In order to strengthen the scheme and deter mis-certification by trusts the following steps will be progressed:

1. Consideration of joint sign-off of trust self-assessments by trust boards and local commissioners;
2. Healthcare Safety Investigation Branch to join NHS Resolution's CAG, which oversees the scheme, and support the CQC check of all submissions;
3. CQC to include cross reference to key lines of enquiry related to trusts' MIS submissions within their inspections of maternity units;
4. Additional verification of a sample of trust submissions by NHS England and NHS Improvement's regional chief midwife and team.

Looking further ahead, NHS Resolution is already leading work on year four of the scheme together with the National Champions, to ensure that it embeds further stretch in the ten actions, drawing on the latest research findings, to continue to drive progress forward.

In order to ensure complete transparency on the process and to introduce a deterrent to mis-certification by trusts, NHS Resolution will publish all interactions with trusts where certification has been queried or revoked and why.

In addition, in line with scheme rules, NHS Resolution will continue to escalate any examples of mis-certification to NHS England and NHS Improvement and the CQC to consider any further regulatory action.

Conclusion

In conclusion the survey results show that trusts have responded positively to the second year of the maternity incentive scheme, reflected in the increased number of trusts achieving all ten safety actions compared with year one and in the improvements in safety culture detailed in this paper.

The safety actions for year three have been drafted with greater clarity and detailed technical guidance has been provided.

The introduction of communications leads from both financial and clinical areas from each trusts has allowed NHS Resolution to communicate key updates and results more effectively. The introduction of a dedicated email inbox (MIS@resolution.nhs.uk) in year two has enabled trusts to submit queries to NHS Resolution which have in turn been communicated to all participating trusts as guidance.

Improvements to the certification process will encourage Board scrutiny of submissions and in turn enhanced consideration of maternity safety issues at Board level.

NHS Resolution is working collaboratively with safety action leads from the CAG to ensure that trusts understand the requirements and share best practice through webinars.

Appendix A

The ten maternity safety actions for year two are summarised here:

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

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

Safety action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?

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

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

Safety action 6: Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?

Safety action 7: Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?

Safety action 8: Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?

Safety action 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Safety action 10: Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?

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