

Maternity Services: NHS Resolution Maternity Incentive Scheme Year 6

Public Board

30 January 2025

Presented for:	Information and Assurance
Presented by:	Rebecca Musgrave, Head of Midwifery/Nursing Thomas Everett, Clinical Director
Author:	Rebecca Musgrave, Head of Midwifery/Nursing
Previous Committees:	None

Our Annual Commitments for 2024/25 are:	
Reduce wait for patients	✓
Reduce Healthcare Acquired Infections by 15%	✓
Reduce our carbon footprint through greener care	✓
Use our existing digital systems to their full potential	✓
Strengthen participation and growth in research and innovation	✓
Deliver the financial plan	✓
Be in the top 25% performing Trusts for staff retention	✓

Risk Appetite Framework				
Level 1 Risk	(✓)	Level 2 Risks	(Risk Appetite Scale)	Impact
Workforce Risk		Workforce Supply Risk - We will deliver safe and effective patient care through having adequate systems and processes in place to ensure the Trust has access to appropriate levels of workforce supply.	Cautious	Moving Towards
Operational Risk		Business Continuity Risk - We will develop and maintain stable and resilient services, operating to consistently high levels of performance.	Minimal	Moving Towards
Clinical Risk		Patient Safety & Outcomes Risk - We will provide high quality services to patients and manage risks that could limit the ability to achieve safe and effective care for our patients.	Minimal	Moving Towards
Financial Risk		Financial Management & WRP - We will deliver sound financial management and reporting for the Trust, aiming to at least	Minimal	Moving Towards

		break even, with no material variances to forecast.		
External Risk		Regulatory Risk - We will comply with or exceed all regulations, retain its CQC registration and always operate within the law.	Averse	Moving Towards

Key points	
1. To provide assurance to the Trust Board on the position of the 10 safety standards, detailed information related to each standard has been shared with the Quality Assurance Committee, bimonthly.	Information
2. The same information has been shared with representatives from the Integrated Care Board (ICB) and the West Yorkshire and Harrogate Local Maternity and Neonatal System (LMNS) through the Leeds Perinatal Quality surveillance bimonthly meetings.	Information
3. Compliance against the 10 safety standards has been included in the report to Quality Assurance Committee (QAC).	Information
4. Following these reviews the committees have received assurance aligned with each safety action and the Trust can evidence compliance with all 10 standards.	Information

1. Summary

NHS Resolution is operating year 6 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to support the delivery of safer maternity care.

This report provides information and assurance to the Trust Board and describes the final position regarding the Clinical Negligence Scheme for Trusts (CNST) year 6 and the processes that have been followed to provide assurance.

The Maternity Incentive Scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution by 12 noon on 3 March 2025.

The Board must declare Yes/No or N/A (where appropriate) against each of the elements within each safety action. The Board declaration form does not include any narrative commentary or supporting documents. It is for the Board to be assured by the evidence they have received and have accessible. The evidence is not routinely reviewed by NHS resolution, but they can by exception request the evidence.

2. Background

A detailed perinatal quality assurance report is presented bimonthly to the Quality Assurance Committee. This report uses the Maternity Incentive Scheme 10 safety actions as a framework to provide ongoing updates supporting progress with compliance against the safety actions. These reports and associated documents then flow through to the Leeds

Perinatal Quality Surveillance bimonthly meeting, which has representation from the ICB and LMNS. This creates further opportunity for check and challenge and external assurance.

Trust Submissions are subject to a range of external validation points including Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK,) Maternity and Newborn Safety Investigations (MNSI) and the national maternity services dataset.

In late 2015, the Department of Health announced a new ambition to reduce the rate of stillbirths, neonatal and maternal deaths in England by 50% by 2030. Saving Babies Lives care bundle (SBL) was introduced in 2016 as a package of care that could be implemented at scale to reduce stillbirth and early neonatal death rates in England and to support with achieving the ambition of the Department of Health outlined above. Version 3 of the Saving Babies Lives care bundle published on 31 May 2023 and can be viewed here, [NHS England » Saving babies' lives: version 3](#) The Three-Year Delivery Plan for Maternity and Neonatal Services sets out that providers should fully implement Version Three by March 2024. The update of SBLCBv3, maintains an approach of continuous improvement. Within each element the focus is on a small number of outcomes with fewer process measures. Implementation of the elements requires a more comprehensive evaluation of each of the organisation's processes and pathways and an understanding of where improvements can be made. Providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element.

The new national SBL 3 implementation tool to track compliance with the care bundle is shared with the Quality Assurance Committee and ICB. Compliance with the care bundle is assessed through review of the SBLV3 tool each quarter and data and compliance validated by the LMNS. Compliance is also discussed through the Leeds Perinatal Quality Surveillance Meetings with LMNS and ICB representation. The November Board report and action plan on implementation of the saving babies lives care bundle demonstrates validated overall compliance with the care bundle is > 50% in all elements and 94% overall.

100% of qualifying cases have been reported to the Maternity and Newborn Safety Investigations Special Health Authority (MNSI) and to NHS Resolution's Early Notification Scheme (ENS). Maternity Services MNSI and NHSR ENS Database is saved quarterly into the MIS Year 6 Safety Action 10 CSU evidence folders, and holds details of all reported cases, relevant MNSI and NHS Resolution reporting details, evidence of MNSI & ENS information sharing and Duty of Candour apology letters shared with families. Evidence also includes the dates of sharing reports, action plans and learning with the West Yorkshire and Harrogate Local Maternity and Neonatal System (LMNS). Every eligible perinatal death has been reported to MBRRACE-UK and the parents have been given the opportunity to share their perspectives of care and raise any questions and comments.

Multidisciplinary training is prioritised to ensure all members of the team have the required knowledge and skills to support safe care.

The Trust work closely with the local Maternity and Neonatal Independent Senior Advocate (also referred to as Maternity and Neonatal ISA or MNISA). This is a senior role being piloted to support women and families in England. This follows the Immediate and Essential Actions identified in the Ockenden review into maternity care at Shrewsbury and Telford Hospital. The Independent Senior Advocate role is independent enough to have autonomy to act for others, senior enough to be able to effectively raise issues at Trust and LMNS board level

and can advocate for women and their families when they cannot do so themselves. This senior role was co-produced by NHS England working alongside maternity and neonatal service users and staff. The aim is to help women, service users and families to be listened to and heard by their maternity and neonatal care providers following an adverse outcome at any time during a pregnancy.

The Trust work collaboratively with service users and the Maternity and Neonatal Voices Partnership (MNVP). Co-production and co-design of services is integral to service delivery and there are multiple examples of ensuring the voice of service users is actively listened to and where possible directly used to support service improvements and educational strategies. The Chair of the MNVP is an active member of internal and external governance and assurance groups, which ensures service user voice representation and that the service is viewed through the lens of the service user.

The Perinatal Quadrumvirate (Clinical Director, Head of Midwifery, General Manager and Neonatal Lead clinician) have participated in the national Perinatal Culture and Leadership Programme (PCLP). The PCLP is designed to support leaders and teams to create and craft the conditions for a positive culture of safety and continuous improvement.

Evidence is available to support a declaration of compliance with all 10 safety actions and sub requirements as set out in year 6 of the Maternity Incentive Scheme. A summary of the evidence available to support the submission is available in Appendix 1.

3. Risk

The declaration form for NHSR states that the Trust Board is satisfied that the evidence provided demonstrates compliance against the 10 safety actions. The Quality Assurance Committee is accountable to and on behalf of the Trust Board, at the December 2024 meeting and bimonthly throughout the year, have scrutinised the evidence, and are satisfied that the evidence provided demonstrates full compliance with the 10 MIS safety actions.

4. Publication Under Freedom of Information Act

This paper has been made available under the Freedom of Information Act 2000

5. Recommendation

Following review and assurance of the evidence for the 10 safety actions by the December QAC, the Trust Board are asked to accept the report and assurance of compliance against the 10 safety actions and respectfully ask for the Chief Executive to sign the compliance declaration form confirming this, which will be submitted to NHSR by 3 March 2025. Appendix 2.

6. Supporting Information

The following papers make up this report:

Appendix 1 Maternity Incentive Scheme Evidence Summary

Appendix 2 MIS Board Declaration Form CEO sign off.

Becky Musgrave

Head of Midwifery and Nursing and Maternity Safety Champion

Womens CSU