

Maternity Incentive Scheme Year 7
Public Board
29 January 2026.

Presented for:	Information, Approval and Decision
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Previous Committees:	None

Link to Strategic Objective	Focus on care quality, effectiveness and patient experience
Link to Provider Capability Assessment	Governance, risk and regulatory
Link to CQC Well-led Statement	Governance, Management and Sustainability
Regulatory Impact	Regulation 17: Good governance

Key points	Purpose
1. The report provides assurance to the Trust Board of the governance processes in place to support the Trust Board declaration of compliance/noncompliance with each of the 10 safety actions defined within Year 7 of the Maternity Incentive Scheme operated by NHS Resolution.	<i>Information</i>
2. The reporting period for Year 7 of the Incentive Scheme is 1 st of December 2024 to the 30 th of November 2025.	<i>Information</i>
3. The evidence has been subject to external reviews by representatives from NHSE and the West Yorkshire and Harrogate LMNS.	<i>Assurance</i>
4. A team with representation from LTHT, ICB, WY& H LMNS, NHSE and PWC met on the 8 th of January 2026 and reviewed all the supporting evidence.	<i>Assurance</i>
5. The evidence review supported the Trusts assessment of compliance with 5 out of 10 of the safety actions.	<i>Information</i>
6. Risks have been reviewed for the safety actions that have not been fully achieved in Year 7 and mitigations are in place to support quality and safety of the perinatal service. Action plans have been developed to be shared with NHSR as part of the Board declaration.	<i>Information and Assurance</i>
7. The Trust Board are asked to review the report and the governance processes used to assess the evidence. If assured the Trust Board are asked to accept the findings of the evidence review and respectfully ask the Chief Executive to sign the Board declaration form ahead of submission to NHS Resolution by the 3 rd of March 2026.	<i>Decision</i>

Level 1 Risk	Level 2 Risks	(Risk Appetite Scale)	Impact
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 break even, with no material variances to forecast.	Cautious	Moving Away
External Risk	Regulatory Risk - We will comply with or exceed all regulations, retain its CQC registration and always operate within the law.	Averse	Moving Away

1. Summary

NHS Resolution is operating year 7 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to support the delivery of safer perinatal care.

The reporting period for year seven of the Maternity Incentive Scheme (MIS) is 1 December 2024 to 30 November 2025. 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 2026.

The 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.

Trusts that do not meet 10/10 Safety actions will not recover their contribution to the CNST MIS fund but may be eligible for a smaller discretionary payment from the scheme to help make progress against actions that have not been achieved.

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

This report provides information and assurance to the Trust Board of the governance processes in place to review the evidence related to each of the safety actions defined within the incentive scheme to inform the final position with year 7 and details systems and processes in place to support further improvements with year 8 of the scheme.

2. Discussion

Following learning from previous years a revised process has been undertaken to support collation and review of the supporting evidence. This has involved working collaboratively with external partners from NHSE, the West Yorkshire and Harrogate Local Maternity and Neonatal System (LMNS) and a representative from an external NHS Trust Provider.

The evidence has been collated and shared at a meeting with representatives from Leeds Teaching Hospitals NHS Trust (LTHT), Integrated Care Board, (ICB), Local Maternity and Neonatal System (LMNS) and NHS England (NHSE) on the 8th of January 2026. A representative from PWC joined the meeting to monitor the process from an internal audit perspective and the accountable officer for the ICB was in attendance. A methodical approach to reviewing the evidence for each element of each safety action was undertaken. Supporting narrative was given by the leadership team with opportunity for check and challenge from all group representatives provided. The review of the evidence supported the Trust assessment for areas of compliance.

There is evidence to support full compliance with 5 out of 10 of the safety actions. The safety actions meeting full compliance are highlighted below:

- (2) Submission of data to the Maternity Services Dataset
- (4) Effective system of clinical workforce planning to the required standards.
- (6) On track to achieve compliance with all elements of the Saving Babies Lives Care Bundle
- (8) Evidence 3 elements of local training plans and in house multiprofessional training
- (10) Reporting of 100% of qualifying cases to the Maternity and Newborn Safety Investigations (MNSI) Special Health Authority and to NHS Resolutions Early Notification Scheme (ENS).

A detailed report including the elements of safety actions that have influenced areas of non-compliance was received by and presented to members of the Perinatal Improvement and Assurance Committee (PIAC) on the 15th of January 2026. The Committee is accountable to and has delegated authority from the Trust Board. Members of the Committee were assured of the systems and processes in place to support the review of the evidence and assessment of compliance status. There were no immediate patient safety risks identified and the systems and processes in place provided assurance to support improved compliance in year 8.

3. Quality and Performance Implications

The Perinatal Improvement and Assurance Committee has been established to support focused oversight of perinatal safety intelligence with information and escalation flowing to the Trust Board. A comprehensive report aligned with the national Perinatal Quality Oversight Model (PQOM) is presented to the Committee by the Head of Midwifery with supporting context as appropriate. The minutes of the meeting and a chairs report are shared with the Trust Board. Where appropriate in alignment with the Maternity Incentive Scheme additional reports including the quarterly Perinatal Mortality Review Tool (PMRT) are shared with the Trust Board. The infrastructure and processes are in place to support timely Board oversight. In the earlier part of 2025, the Quality Assurance Committee which has membership of Executive and Non-Executive Directors received the mortality data. It is acknowledged that this didn't meet the requirements of Safety Action 1 but did support oversight and escalation to the Trust Board.

Maternity and Neonatal Safety Champions support floor to Board escalation and communication of perinatal quality and safety. The LTHT model has been reviewed and revised to ensure it meets the national guidance. Regular meetings and walkarounds are scheduled throughout the year. This will facilitate receipt and review of documents detailed within the Incentive Scheme and enhance structures to support escalation of concerns to the Trust Board.

The perinatal leadership team and Safety Champions work collaboratively with service users and the Maternity and Neonatal Voices Partnership Chair to recognise and respond to service user feedback and use this intelligence to coproduce educational strategies and support service development. The review and revision of the Safety Champions model will enhance reviewing and reporting mechanisms to support ongoing improvements with the scheme in future years.

4. Financial Implications

There is a financial impact of the loss of Maternity Investment Standard Rebates. Action plans including financial support required have been developed and will be submitted to NHS Resolution as part of the Board declaration.

5. Risk

Whilst in the NHS England Quality Assurance and Improvement process and taking actions to address the CQC regulatory breaches the Trust is moving away from the risk appetite set by the Board for External risk, Regulatory risk and Clinical Risk, Patient Safety and Outcomes.

6. Communication and Involvement

The Trust have produced communications for members of the public to provide assurance regarding using maternity and neonatal services at LTHT.

7. Improving Health Equity

Not applicable for the report but inextricably linked to quality and safety of the perinatal services.

8. Publication Under Freedom of Information Act

This paper is currently exempt from publication under Section 22 of the Freedom of Information Act 2000 but will be made available to the public on 29th of January.

9. Recommendation

The Trust Board are asked to receive the information and assurance within the report and if assured of the findings of the review respectfully ask the Chief Executive to sign the Trust Board declaration ahead of submission to NHSR by the 3rd of March 2026.

10. Supporting Information

The following papers make up this report:

1. NHS Resolution Trust Board declaration form