NHS Resolution

MIS evaluation findings

Nick Rigg
Senior Programme Lead: Maternity Schemes Evaluation and Implementation, NHS Resolution

Professor Graham Martin
Research Professor, *THIS Institute*

The rationale

NHS Resolution

- evidence-based decision-making
- scheme development

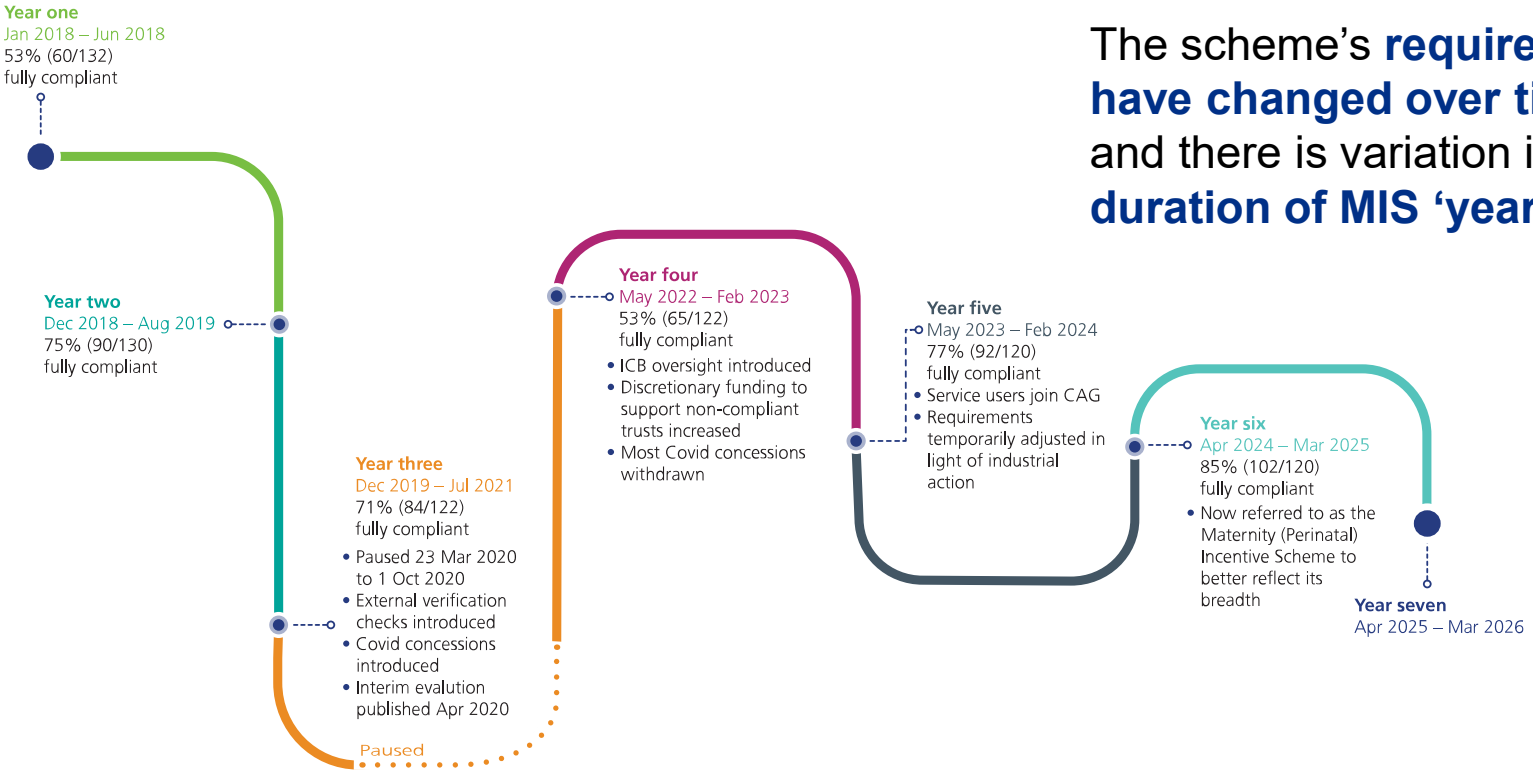
Our aim

- to reflect upon the **history**, where MIS has had the most **impact**;
- deeper insights into its **processes**;
- understand how the scheme is **experienced**; and
- **adds value** within an **evolving** maternity and neonatal landscape.

To support this, we have considered **stakeholder feedback, compliance** and **outcome** data, and other **improvement metrics**.

Considerations

NHS Resolution



The scheme's **requirements have changed over time** and there is variation in the **duration of MIS 'years'**

The approach

This evaluation covers **MIS years 1 to 6**.

To ensure a robust evaluation process, **NHSR commissioned The Healthcare Improvement Studies Institute (THIS Institute)** to undertake independent qualitative work and targeted quantitative analysis, to support additional **internal (NHSR-led) research and data analysis**.

A **mixed methods approach** was used to enable a comprehensive assessment of the scheme's impact, considering both stakeholder feedback and statistical insights.

Data analysis

Page 14 of the report outlines the various elements of data analysis undertaken, some in-house and some independently by THIS Institute

THIS Institute

- **Qualitative** research
- **Quantitative** research
  - Year-on-year compliance
  - Impact on compliance of region, trust size
  - Predictive analysis of individual safety action compliance
  - Impact of full compliance, non-compliance and individual safety actions on future compliance
  - Safety Action 5 and 8 impact on outcomes

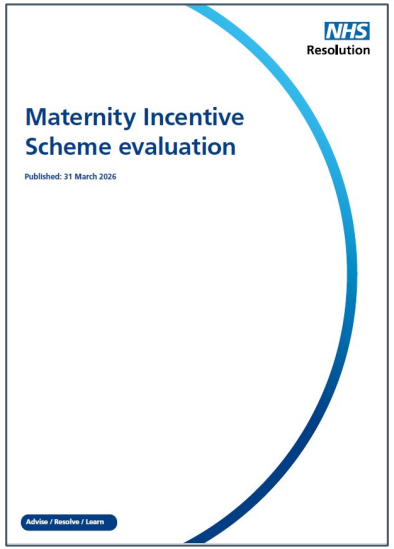
Data analysis (continued…)

NHS Resolution

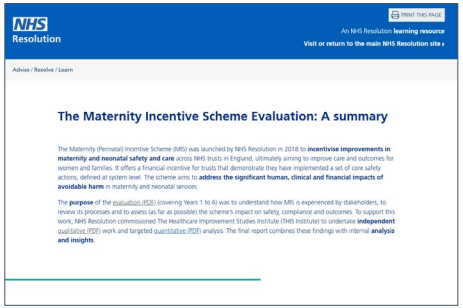
NHS Resolution

- Year-on-year compliance
- Impact on compliance of region, trust size and contribution
- Discretionary funding
- External verification
- Reverification
- MIS compliance vs. stillbirth, neonatal mortality and maternity claim rates, CQC rating and Maternity Neonatal Improvement Support Team (previously MSSP) engagement

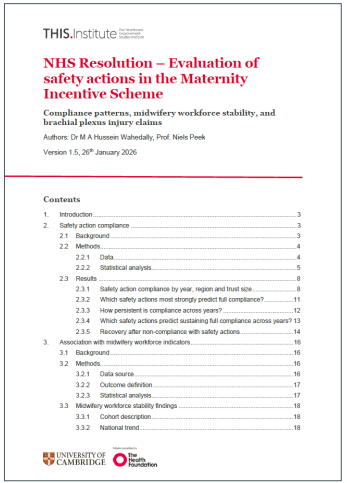
Outputs



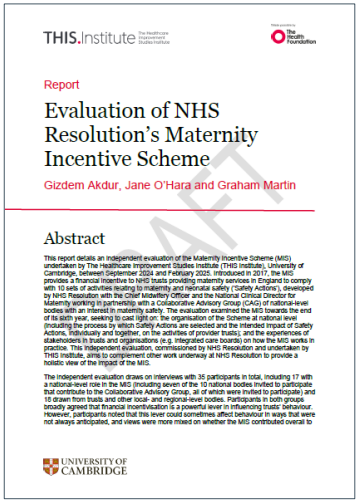
Maternity Incentive Scheme evaluation
https://resolution.nhs.uk/wp-content/uploads/2026/03/MIS-Evaluation-Report.pdf



MIS evaluation 'at a glance' summary
https://resolution.nhs.uk/learning-resources/the-maternity-incentive-scheme-evaluation-a-summary/



THIS Institute quantitative analysis
http://resolution.nhs.uk/wp-content/uploads/2026/03/THIS-Institute-MIS-Quantitative-Report.pdf



THIS Institute qualitative evaluation
http://resolution.nhs.uk/wp-content/uploads/2026/03/THIS-Institute-MIS-Qualitative-Report.pdf

Insights

- **…challenging to attribute improvements in maternity and neonatal safety to any single initiative** and safety is achieved through **numerous interconnected, system-wide efforts**.
- demonstrating statistically significant relationships between MIS compliance and external data difficult due to **high overall compliance** and **limited data variability**.
- **Safety Actions 3, 4, 5 and 6** – have supported national programmes such as Avoiding Term Admissions into Neonatal Units, workforce planning and the Saving Babies' Lives Care Bundle, enhancing compliance with safety standards and best practices led by system partners.

Insights

- Over time the **external verification** of safety actions has resulted in a net upgrade in compliance rather than downgrade.

- Over time, **reverification** has been associated with a reduction in downgrades and an increase in the proportion of checks **reconfirming compliance**.

- Across all years, there were only six occasions when a trust did not seek **discretionary funding**.

Thank everyone that has contributed to the evaluation

THIS.Institute The Healthcare Improvement Studies Institute

Made possible by The Health Foundation

Evaluation of the Maternity Incentive Scheme

Graham Martin

The Healthcare Improvement Studies Institute

graham.martin@thisinstitute.cam.ac.uk

@THIS_Institute
@graham_p_martin

Background

- As part of ongoing evaluation efforts, NHS Resolution commissioned THIS Institute to lead independent evaluations of
  - the Maternity Incentive Scheme
  - the Early Notification Scheme
- MIS evaluation took place late 2024 to early 2025
- EN Scheme evaluation is ongoing

- Many thanks to those who contributed!

MIS: evaluation questions

1. How is the process of selecting Safety Actions for the MIS working in practice?
2. What is the view of stakeholders at the level of healthcare provider organisations on the MIS and its impact?

- Qualitative interviews with
  - 17 Collaborative Advisory Group members and senior NHS Resolution staff (focusing on the work of the CAG and the evolution of the Scheme through time)
  - 18 people at the 'sharp end' of the Scheme – in trusts and other local bodies such as ICBs (focusing on how providers and other organisations approach the Scheme in practice)

3. Is there sufficient variation in compliance to infer causal effects on outcomes? What is the availability and access of potential outcome data?

- Statistical modelling of
  - Associations between individual safety actions and full compliance, persistence of compliance over time at trust level, trusts' recovery patterns following non-compliance
  - Associations between compliance and (i) maternity workforce indicators and (ii) brachial plexus injury claims

High-level findings: qualitative

- Near unanimity on the **power** of financial incentives in commanding trusts' attention
- Many argue that **board-level attention** to maternity care would be much weaker without it
- Less agreement on the consequences of MIS for **safety in practice**: examples of greater leverage in securing resources for improvement, and of 'box-ticking' responses
- Seen by some as an **'industry'** with grave consequences for staff wellbeing in places
- Use of **returned funds** seems to vary: some invested in maternity; some swallowed by trust deficits
- Lots of **suggestions for improving** the Scheme

High-level findings: quantitative

- Levels of compliance were high overall (80%+ for all 10 safety actions)
- There was variation in compliance levels by region but not by trust size (volume of births)
- Full compliance in prior years was strongly predictive of full compliance in later years
- Probability of recovery following non-compliance was generally high (median 69% across safety actions) but varied by safety action (e.g. 58% SA9; 91% SA2)
- No evidence that the introduction of MIS was associated with improvements in midwifery workforce stability or reductions in sickness rates, but trusts complying with SA5 had modestly higher workforce stability than those not complying
- There was no detectable relationship between SA8 compliance and brachial plexus injury claims – but claims are rare and post-MIS data remain immature due to lags

Qualitative findings in depth: the scope and purpose of MIS

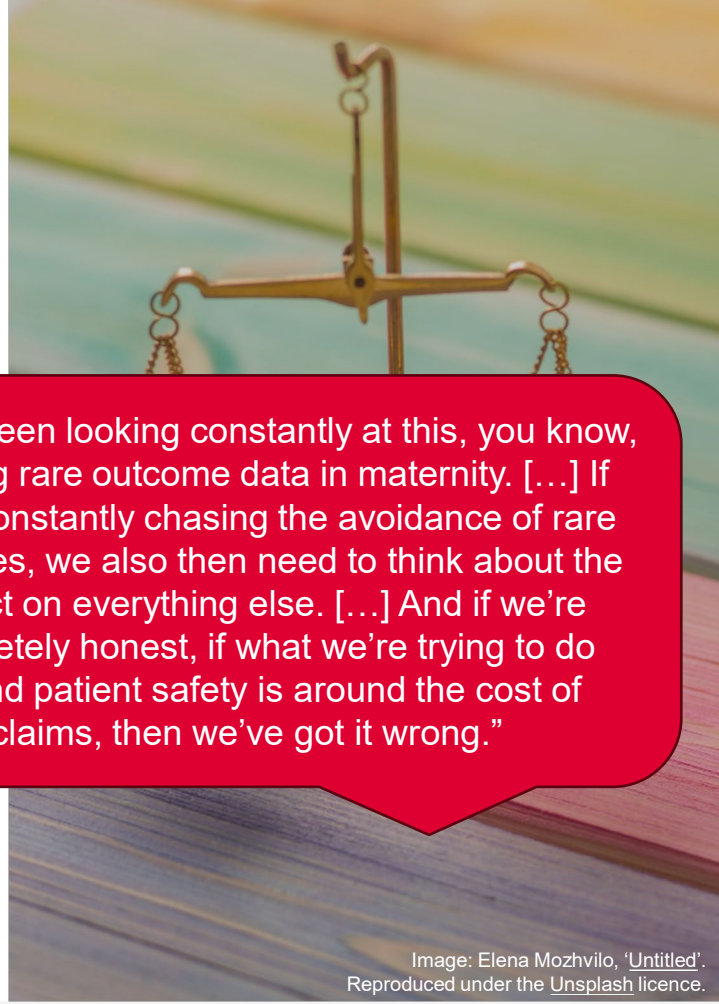
- Differing views evident about how MIS's contribution to safety might be optimised
- Has the focus of the Scheme evolved from the original focus on reducing risk of intrapartum brain injury? Should it?
- Safety narrowly and broadly conceived?
  - Rare, high-consequence, high-cost claims
  - Broader aspects of infant and maternal safety (and quality and experience)
- Risk of scope creep or opportunity to maximise the impact of an apparently effective approach to incentivisation?

Qualitative findings in depth: the scope and purpose of MIS

- Differing views evident about how MIS's
- [illegible]
- [illegible]
- [illegible]
- Risk of scope creep or opportunity to maximise the impact of an apparently effective approach to incentivisation?

"I would like to see a smaller number of [Safety] Actions and for those to be focused on the areas which are, I suppose, giving the most bang for the buck in terms of safety impact. […] So those things are things like multidisciplinary training for obstetric emergencies, for – yeah, for those high-impact actions that resonate in terms of what we see on the clinical negligence claims, particularly the highest-value clinical negligence claims."

"We've been looking constantly at this, you know, chasing rare outcome data in maternity. […] If we're constantly chasing the avoidance of rare outcomes, we also then need to think about the impact on everything else. […] And if we're completely honest, if what we're trying to do around patient safety is around the cost of claims, then we've got it wrong."



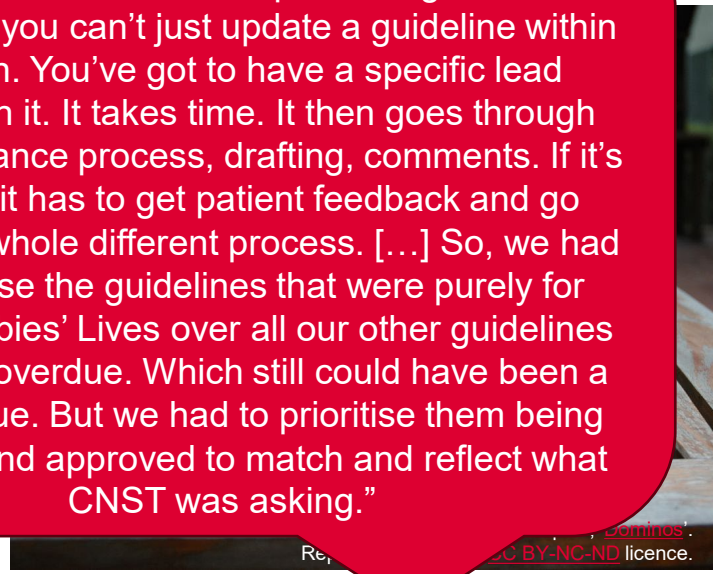
Qualitative findings in depth: consequences intended or unintended?

- Participants in trusts described extensive efforts to ensure adherence to the standards set out in Safety Actions each year
- But sometimes these seemed to participants excessive or disproportionate
- What participants described is exactly in line with the theory of change of the MIS
  - Financial incentivisation leading to behaviour change…
  - …in relation to things that might otherwise be neglected
- But there are opportunity costs (including for safety)
- And attention to ‘minutiae’ damaged some participants’ belief in the Scheme

Qualitative findings in depth: consequences intended or unintended?

"If you don't meet one individual action within one Safety Action, you've failed the whole programme potentially. For our organisation, last year, MIS brought in [several] million. So, if for instance we did not meet Birthrate Plus requirements, we would fail and we would lose [several] million. So that gives you leverage when it comes to, if a turnaround director came into the organisation, and said, we need to lose six posts from every service, for instance, we, in a way, would be protected because we would then fail in MIS."

"The Saving Babies' Lives element. So, having – so, in our trust we had to update 11 guidelines. Obviously, you can't just update a guideline within a month. You've got to have a specific lead leading on it. It takes time. It then goes through the governance process, drafting, comments. If it's a leaflet it has to get patient feedback and go through a whole different process. […] So, we had to prioritise the guidelines that were purely for Saving Babies' Lives over all our other guidelines that were overdue. Which still could have been a safety issue. But we had to prioritise them being updated and approved to match and reflect what CNST was asking."



- And att[illegible]ion to 'minutiae' damaged some participants' belief in the Scheme

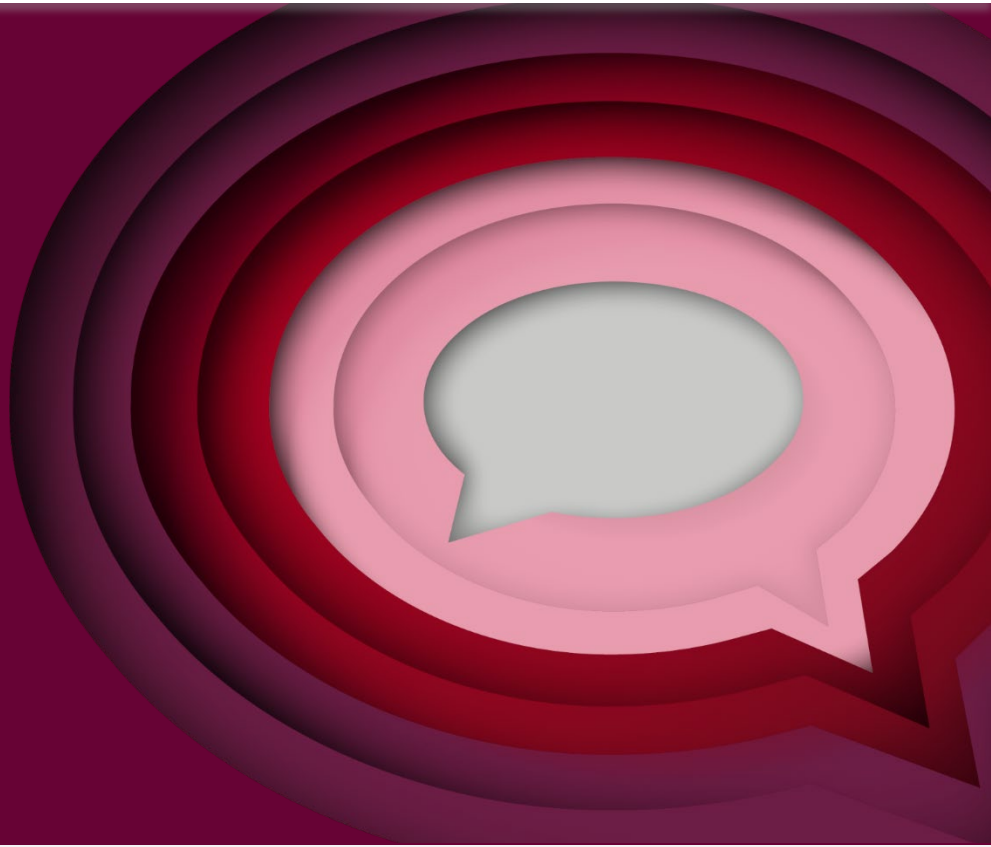
Implications for NHS Resolution

- Three overarching areas identified for consideration by NHS Resolution, each including a range of more specific ideas

1. **The purpose and place of the MIS**: what aspects of safety it should focus on; the place of the MIS in a changing maternity (governance) system
2. **Optimising the Safety Actions and minimising administrative burden**: optimising the number and choice of Safety Actions; ensuring consistency and clarity for trusts; maximising alignment with demands from other agencies
3. **Incentivising and supporting improvement**: supporting trusts organisations around use of rebates and discretionary funding; enhancing understanding among trusts and other bodies (e.g. LMNS) about their role in the MIS

Made possible by The Health Foundation

Thank you.



thisinstitute.cam.ac.uk

@THIS_Institute
@graham_p_martin

Acknowledgements

- Jane O’Hara
- Gizdem Akdur
- Mary Dixon-Woods
- Niels Peek
- Hussein Wahedally