

Briefing: What's next for the Maternity Incentive Scheme?

June 2026

Summary

The Maternity (Perinatal) Incentive Scheme (MIS) is a financial incentive programme, established by NHS Resolution (NHSR) in 2017, which aims to enhance maternity and neonatal safety within NHS Trusts in England. In March 2026, NHSR published an evaluation of the first six years of the MIS, which found that the scheme has raised the profile of maternity and neonatal safety at Board level and that compliance has improved. However, understanding the impact of the scheme's overall impact on maternity and neonatal safety remains a challenge, along with the risk of unintended consequences.

While some findings from the evaluation have been integrated into the MIS Year Eight core standards (April 2026 to March 2027), this will be a transitional year as NHSR responds to the evaluation findings as well as the findings of the National Maternity and Neonatal Investigation (due to be published in June 2026) and the subsequent work of the Taskforce.

This briefing will explore some of the key findings within the evaluation, whilst highlighting areas for further consideration by NHSR and the Taskforce, including:

- The purpose of the scheme, its theory of change, the effectiveness of each safety action and how they contribute to the scheme's impact. Consider output, outcome and impact metrics which could make evaluation more feasible.
- How to ensure that Trust Boards focus on the safety of maternity and neonatal services by proactively seeking out and resolving issues rather than focusing on compliance and reputation management.
- What external assurance of MIS submissions and the use of reimbursements and discretionary payments is needed to build confidence in the scheme and reduce perverse incentives.

Background

The Maternity (Perinatal) Incentive Scheme (MIS) is a financial incentive programme, established by NHSR in 2017, which aims to enhance maternity and neonatal safety within NHS Trusts in England. Trusts delivering maternity and neonatal services contribute an additional 10% on top of their Clinical Negligence Scheme for Trusts (CNST)¹ maternity contribution. These additional contributions constitute the CNST MIS fund. Trusts that achieve compliance with all safety actions receive their MIS contribution back, along with a share of unallocated funds. Trusts who do not meet all actions can apply for discretionary funding from the pooled MIS contributions to help meet any unmet safety actions, if they are able to demonstrate a business case for improvement.

¹ CNST is a risk-pooling scheme administered by NHS Resolution that provides indemnity coverage for NHS Trusts against clinical negligence claims. The cost of the premium is set by NHS Resolution annually for each Trust, based on a range of historic and controllable factors (e.g. size of service in each organisation, claims history and the number of staff). [How are CNST contributions calculated? - NHS Resolution](#)

Since its inception, the MIS has had a mixed reputation, particularly due to the self-reporting nature of the scheme, which [some critics](#) have said means that efforts are focused on proving compliance rather than making the improvements to safety which underpin them.

An [interim evaluation](#) of the scheme was published in 2020 based on NHSR analysis of compliance with the safety actions and a survey of participating Trusts. While this provided some insights, analysis of the impact on maternity safety was not objective or robust. Analysis of the impact was based on survey responders' opinions with no evidence required and no detail provided on the representativeness of the survey.

In March 2026, NHSR published [an evaluation](#) of the first six years of the MIS, which draws on [quantitative](#) and [qualitative](#) evaluations by THIS Institute as well as NHSR-led research and analysis.

Evaluation findings

This section includes some of the key findings from the evaluation, with areas for further consideration in **bold**.

Overall impact on safety

The evaluation summary refers to "some weak (but not statistically significant) correlation between MIS compliance and external trends such as stillbirth and neonatal deaths". However, this overstates the findings. Analysis of the impact on stillbirth and neonatal deaths was only possible for one out of 10 safety actions (Safety Action 6. Demonstrate that you are on track to achieve compliance with all elements of Saving Babies Lives Care Bundle Version 3) and found a weak (not statistically significant) association with reduction of stillbirths and no notable correlation with neonatal death rates. No other evaluation of the impact on safety outcomes² was possible. For the remaining nine safety actions, no analysis of the impact on perinatal mortality was possible.

The evaluation notes the challenge of directly attributing improvements in maternity and neonatal safety to individual initiatives, particularly as "the web of activities relating to maternity safety at a national level was seen ... to have become more tangled in recent years" ([p.60](#)). However, there are established methods for evaluating the impact of complex interventions³ like the MIS but they require a stronger theoretical foundation to evaluate whether it is working in the way it is intended.

The MIS evaluation does not have a strong foundation in the scheme's theory of change, instead analysing correlation with the overall reduction in national perinatal mortality rates over the past decade (see NHSR's [summary of the evaluation](#)). This analysis provides no insight as to whether or how the scheme works, particularly as the reduction of perinatal mortality rates has slowed over time while compliance has risen.

NHSR should develop and publish a more robust theory of change for the MIS which includes a way of considering the implications of adding or removing safety actions and subsequently evaluating the impact of those decisions. Safety actions or sub-actions should be limited to issues which the organisation, whose behaviour is being incentivised, has direct control over ([p.64](#)).

² The quantitative evaluation considered the impact of SA5 (demonstrating an effective system midwifery workforce planning) on the workforce stability index, which found no measurable change in midwifery stability nationally although there was some association in individual Trusts between adherence to the SA5 and improved staff retention.

³ Defined as multiple interacting interventions and activities that are organised around a high-level goal.

The purpose of the MIS

Part of the challenge of evaluating the impact of the MIS is the lack of consensus around the scheme's objectives; "For some, the distinctiveness of the MIS in a system with no shortage of maternity safety-related initiatives was its focus on avoidable brain injury and other rare, high-impact harms. For others, a broader conceptualisation of maternity and neonatal safety is required, not least because actions intended to minimise the likelihood of these low-frequency, high-consequence impacts could affect other aspects of safety, quality and service user experience" ([p.63](#)). Clarifying the scheme's objectives is critical to inform its design and evaluate its impact.

This requires action from NHSR, and others involved in the MIS, to reach an agreement on the objectives of the scheme.

As noted above, the relationship between compliance with the MIS and maternity safety is uncertain. The qualitative evaluation suggests that "one way of addressing this might be to shift the focus of the MIS towards outputs, outcomes or impacts. Infrequent outcomes (such as maternal mortality and brain injury [or stillbirths and neonatal deaths]) may not be easy to attribute reliably to Safety Action-related activity. More intermediate outcomes (for example, knowledge or capability of staff) might be more feasible to measure. However, a focus on outcomes has potential downsides, and may not be fully compatible with the objectives of the Scheme" ([p.63](#)).

After clarifying the scheme's objectives, NHSR should develop (or, if one exists, refine) the theory of change to identify output, outcome and impact metrics which could make evaluation more feasible.

The [MIS aims to support more equitable maternity and neonatal care](#). However, given the lack of progress over the lifetime of the MIS to reduce inequalities, **further consideration of how the scheme tackles inequalities is required.**

The place of the MIS in an evolving maternity system

"The web of activities relating to maternity safety at national level was seen by national- and local-level participants alike to have become more tangled in recent years. While in principle the MIS's role was to build on initiatives that were already present – by adding a financial incentive to 'must-dos' or 'should-dos' dictated by others – the experience in practice was of additional burden due to different timescales, measurement approaches, or other requirements" ([p.60](#)).

Participants noted that issues in other parts of the system – notably failures of the Care Quality Commission (CQC) – complicated the role of the MIS. The evaluation noted the importance of a functional system of regulation, management and governance to the proper working of the MIS.

The National Maternity and Neonatal Investigation has [identified system configuration as one area which will require further attention from the taskforce](#). **The taskforce should work with NHSR, government, regulators, and other arm's length bodies to agree the role of the MIS, to ensure impact and reduce the risk of scope creep. A clear theory of change for the MIS would help to demonstrate how it will enable wider systemic changes.**

Strengthened Board engagement

Strengthened Board engagement is one of the headline findings from the qualitative analysis. This notes that financial incentivisation is a strong lever on organisations. The assumption is that this engagement could lead to actions to improve safety "from raising the profile and understanding of an

otherwise-neglected service at Board level, through professionalisation of safety management within services, to the greater leverage at service level enjoyed by those pressing for improvements” (p.57).

However, it is not clear whether the scheme incentivises broader curiosity and [problem-sensing](#) behaviour by Board members about the safety of their maternity and neonatal services, or whether engagement is limited to compliance with the scheme and the financial implications. The [Joint Policy Unit's 2023 review of Board papers](#) found limited discussion of maternity and neonatal services at public meetings, with the detailed discussions taking place elsewhere. The MIS Year Eight Core Standards state that Trusts must ensure that “findings arising from detailed scrutiny at the Quality Governance Committee (or equivalent) are formally escalated to the Executive Board, providing full oversight in line with good governance practice and the expectations of the Perinatal Quality Oversight Model” (p.26).

The taskforce should consider – whether through the MIS or otherwise - how to ensure that Boards engage with the safety of maternity and neonatal services rather than focusing on compliance or reputation management. Further analysis of Board papers is required to determine whether more detailed discussions or reporting from sub-committees at Board level are now taking place.

It is also not clear whether greater Board engagement leads to actions which improve safety. The evaluation noted that the MIS may skew priorities for improvements within services, with greater time and resources spent on activities that might mean the difference between compliance / non-compliance, displacing activities with a more substantial impact on safety, user experience, or other quality metrics.

Further consideration of the impact (positive and negative) of Board engagement is required.

Use of funds

The evaluation found mixed reports on how Trusts used rebates from the scheme. Only a few were confident that their organisation reinvested all the money in maternity care, and some indicated that maternity received no benefit.

Discretionary payments (to address areas of non-compliance) were viewed favourably but not all were aware of them or what was required to access this money. As rebates are not ringfenced for maternity and neonatal services this may also lead to perverse incentives, with some reports that “sometimes, leaders of maternity services within Trusts might prefer a non-compliant declaration that would allow them to submit an action plan that might attract discretionary funding for improvement from NHSR, since they expected that little if any of the full rebate arising from a compliant declaration would reach the maternity service” (p.61).

There needs to be greater accountability for the use of reimbursements and discretionary payments. The Taskforce should consider whether ring-fencing MIS rebates would reduce some of the perverse incentives created by the current system.

Currently Trusts are responsible for the use of discretionary payments but there may be a need for NHSR or other bodies to ensure the effective use of funds towards agreed action plans.

Scheme assurance

Trusts self-certify their compliance with the scheme, and submissions require sign off from the Trust Chief Executive and Board. Submissions are subject to external validation by NHSR where external data sources are available⁴ and are sense-checked with the CQC before the results are finalised.

⁴ This only applies to SA1, SA2. SA10

If any concerns are raised about a Trust⁵ or a previous MIS submission, NHSR carries out a 'reverification' process where Trusts are asked to reconfirm whether they met all safety actions and if this does not "allay concern" then NHSR reviews the evidence of the submission (p.20). Most MIS reverifications are triggered by CQC inspections (44%), concerns raised by MBRRACE-UK data (27%) and where a reverification of one year has prompted a review of other years for the same Trust (19%). Few reverifications are prompted by family concerns (1%) or Maternity and Newborn Safety Investigation (MNSI) reports (1%). Over time, the reverification rates appear to be reducing, with only one Trust downgraded in Year Six compared to 23 in Year Two at the time of publication (although this may change in the future).

Although some stakeholders questioned the validity of submissions, quantitative data suggests that submissions have become more robust over time, and external reverification is now more likely to upgrade rather than downgrade reported compliance (although this may also provide further evidence for the perverse incentives noted in the previous section).

From Year Eight, NHSR will carry out and pilot additional assurance measures, which will be particularly important as the scheme moves away from the previous mandated evidence model and as Integrated Care Boards (ICBs)⁶ step back from their assurance role. NHSR will introduce a mid-year 'spot check' whereby one Trust per region "may" be randomly selected to provide NHSR with a progress update against a randomly selected safety action. Collated and anonymised themes from the findings of these spot checks "may" be shared to support wider system learning. NHSR will pilot additional assurance approaches in 2026, including service user and peer review models.

NHSR should share learning from the additional assurance pilots and consider whether random spot checks provide sufficient confidence in Trust declarations. NHSR should also consider why so few reverifications are prompted by families' concerns and whether the current model sufficiently captures their perspectives.

Administrative burden

There was widespread agreement in the qualitative evaluation regarding the significant workload the MIS created for Trusts and local systems. Some said that the MIS "had turned compliance into an "industry" in an already pressured system" (p.8).

To reduce this administrative burden, Year Eight MIS has streamlined safety actions from 10 to six. Two have been removed (SA2 and SA3) and actions with a similar purpose have been combined (SA4 and SA5, SA1 and SA10). The MIS states that Year Eight focuses on the set of actions with the "strongest evidence for reducing the risk of avoidable catastrophic harm and improving perinatal outcomes" (p.14). The Collaborative Advisory Group is responsible for evolving the scheme's requirements each year. However, given the evaluation could not analyse the impact on outcomes for any of the safety actions that were dropped or combined, it is not clear what evidence base has been used for these decisions. Not all national-level respondents felt the Collaborative Advisory Group had found the right approach to deliberation, with some suggesting the time was right for a more fundamental review of the Safety Actions individually and together (p.59).

The taskforce and NHSR should consider a more fundamental review of the safety actions individually and for the scheme overall. This should be closely linked to the review of the purpose of the scheme and the theory of change. If the scheme continues, the number of safety actions should be minimised as far as possible given the administrative burden of the scheme.

⁵ From families, Maternity and Newborn Safety Investigations, coroner's or Early Notification Scheme reports, the CQC or whistleblowers.

⁶ Previously, the Board declaration of compliance with the MIS had to be signed by an ICB representative also.