Better board oversight needed to save babies' lives

Sands & Tommy's Policy Unit

Working together to save babies' lives

Board oversight: at a glance

Trust boards' regular oversight of the quality and safety of maternity and neonatal services has been the subject of successive inquiries and reviews. We reviewed publicly available board papers and minutes for seven NHS Trusts in England to analyse whether the information presented to boards, the process for review and actions taken enabled boards to deliver on this responsibility. Our findings across these three areas raise questions about boards' ability to have a full understanding of the performance of maternity and neonatal units under their direction under the current system.

Our review has highlighted the need for:

- Further guidance on the minimum metrics to be submitted to boards, including any new measures identified by the Maternity and Neonatal Outcomes Group to provide an early warning of service quality and safety declining;
- Better ward-to-board communication to contextualise data, including more analysis from Clinical Service Leaders to interpret metrics and more board member engagement with wards and staff;
- Reports which reflect on and contextualise metrics and trends over a longer time frame in addition to regular service monitoring dashboards;
- A review of current systems and processes in each Trust and whether they allow boards to have meaningful oversight over the quality and safety of services;
- Transparent reporting of issues discussed outside of public board meetings, such as at sub-committee level;
- A review of whether the maternity incentive scheme prioritises financial certainty and reputation management over a culture of learning and improvement;
- Clarity over the role of Local Maternity and Neonatal Systems in oversight of quality and safety and the implications for Trust boards' responsibilities.

While our findings relate to Trusts in England, other reports suggest that there is an opportunity for all of the devolved health services to review and improve board oversight processes.

Introduction

The safety and quality of maternity and neonatal services are the responsibility of the board in each Trust. However, the actions (or inactions) of leadership have come up frequently in inquiries and reviews[i]. The Ockenden review[ii] into maternity services at Shrewsbury & Telford Hospital NHS Trust, found that the Trust board did not have oversight, or a full understanding of issues and concerns within the maternity service. This led to a lack of strategic direction, a failure to make effective changes and an absence of accountable implementation plans.

Three themes related to board oversight have been reoccurring in recent inquiries and reviews: intelligence provided to boards; the process by which boards review the data and information; and the actions that are taken as a result (see Figure 1).

Data & intelligence	Robust & candid review process	Early action to address concerns
Relevance & coverage of metrics	Scrutiny of data and intelligence	Request for further information
Quality and accuracy of data	Problem-sensing	Mitigation actions agreed
Breadth of intelligence	Interest in safety & quality of care, workplace culture and staffing	Action plans monitored
Presentation & analysis	Safety champions at board level	

Figure 1. Building blocks for board oversight of quality and safety of maternity and neonatal services.

Data & intelligence

To provide boards with regular oversight of the quality and performance of their maternity and neonatal services, progress and exception reports must be presented by clinical services. The Ockenden review recommended that all maternity serious incident reports (and a summary of key issues) must be sent to the Trust Board and the Local Maternity System (LMS) for scrutiny, oversight and transparency at least every 3 months.

NHS England has set out minimum data measures for maternity and neonatal dashboards. Although most metrics are consistent, there are some discrepancies between different documents such as the Revised Perinatal Surveillance model[iii] and the role descriptor for the non-exec board safety champion[iv]. A combined list would include the following metrics:

- All maternity and neonatal Serious Incidents;
- Incidents graded as moderate harm or higher;
- Trust position in meeting national ambition trajectories for stillbirth, brain injury, maternal mortality, neonatal mortality and preterm birth rates; implementation rates of the Saving Babies' Lives Care Bundle Version 2 (now Version 3) and continuity of carer;
- Safe staffing levels;
- Staff feedback from frontline champions and walkabouts;
- Staff survey feedback;
- Service user feedback;
- Progress against maternity incentive scheme requirements;
- Correspondence or concerns raised by Regional Chief Midwife and Lead Obstetrician, Coroners, Deaneries, national bodies including NHS Resolution, the Care and Quality Commission (CQC), Health Safety Investigation Branch (HSIB) or the Invited Review process.

Robust and candid review processes at board level

The Maternity Incentive Scheme (Safety Action 9) states that Trusts must "demonstrate there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues."[v] This includes the importance of regular and thorough reviews of data and intelligence (including concerns from staff and service users) on Trust safety performance in maternity and neonatal services. Review processes should actively seek out weaknesses or challenges in the system by requesting a range of data and intelligence and being "problem-sensing"[vi]. Review processes should not be "comfort-seeking" by taking undue confidence in the data available and being unwilling to seek out further information that might disrupt this view.

Trust leadership at the executive and board level is reviewed by the CQC during inspections, to monitor when reputation management is superseding transparency. However, board failures continue to be identified. The Kirkup review of maternity and neonatal services in East Kent[vii] found that, among other issues, the Trust board missed several opportunities to properly identify the scale and nature of problems and to put them right. Patient safety inquiries for other NHS services found instances where boards appear more concerned with financial performance and the potential for reputational damage, compared with the safety and quality of care, workplace culture and staffing levels[viii].

Knowledge and engagement are critical components in a board's ability to provide a robust review of maternity and neonatal services' data and intelligence. In its responses to the Kirkup report (Recommendation 4ii)[ix], the Government stated that Trusts must ensure there is proper representation of maternity care on their boards. CQC has noted[x] the important role that an engaged and knowledgeable safety champion can play to facilitate communication from ward-to-board. One of the immediate and essential actions outlined in the Ockenden review included the appointment of a non-executive director (NED) as a maternity safety champion for each board. The NED board maternity safety champion should have a specific responsibility to ensure that women and family's voices across the Trust are represented at board level and to collaborate with the maternity and neonatal Safety Champions.

Early action to address areas of concern

Actions to address concerns could include requests for further information or an action plan to mitigate the risks identified. The Ockenden review found no thorough scrutiny of reports at board level and an acceptance of statements without evidence. For example, the Trust reported that the maternity incentive scheme training requirement were achieved but no evidence was shared with, nor asked for by, the board.

The Kirkup report also noted that despite the Trust board endorsing a succession of action plans, the plans and the way in which the Trust board engaged with them "masked the true scale and nature of the problems"[xi].

Our aim

Each Trust and its board, supported by senior maternity and neonatal staff and the board-level perinatal safety champion, are ultimately responsible for the quality of services provided and for ongoing improvement. The aim of this research was to review whether the information presented to boards - and subsequent review and discussion – enabled boards to deliver on this responsibility.

Methodology

We reviewed publicly available board papers from seven NHS Trusts in England to analyse board oversight of maternity and neonatal services. We limited the scope to Trusts in England to tailor the policy implications because health care is a devolved matter.

We used Trust-level data from Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) on stillbirth and neonatal mortality rates, excluding congenital abnormalities, from 2019 to 2021 to select the sample of Trusts. Mortality rates can vary between different Trusts depending on the level of care they provide, so we used the MBRRACE-UK comparator groups red, amber and green (RAG) rating to identify Trusts that were performing better and worse than their comparator group. Using a series of rules, we identified 10 higher and lower performing Trusts and Boards. Two were outside of England and excluded. Board papers for one Trust were not available online.

A summary of the profile of the seven remaining Trusts which were reviewed is included in Table 1.

Trust	Region	Comparator group	Extended perinatal mortality rating (2021)[xii]
Trust 1	South East	Level 3 NICU & neonatal surgery	6.64
Trust 2	Midlands	2,000 – 3,999 births	4.17
Trust 3	North East and Yorkshire	4,000 or more births	4.46
Trust 4	London	Level 3 NICU & neonatal surgery	5.29
Trust 5	North East and Yorkshire	Level 3 NICU & neonatal surgery	5.78
Trust 6	East of England	4,000 or more births	4.02
Trust 7	North East and Yorkshire	Level 3 NICU & neonatal surgery	7.81

Table 1. Summary of Trusts reviewed

Although we used perinatal mortality data to select the sample, our review focused on whether board reporting and discussions were robust and candid, rather than on the Trust's performance. CQC ratings, National Neonatal Audit Programme (NNAP) metrics and mortality data from MBRRACE-UK were included as contextual information after the Board papers had been analysed.

We developed a framework (see Appendix 1) to review the quality and content of reports and data presented to the sample of boards, the oversight the boards demonstrated and whether any actions were agreed to address identified issues.

This work was not intended to single out particular Trusts. Instead, we wanted to find common themes between Trusts to inform policy recommendations. For this reason, we have focused on the findings and anonymised the Trusts in this document. However, the completed analysis for each Trust is available on request.

Key findings

Quality and safety intelligence

Across the sample of public board papers, a large amount of information is submitted for each meeting covering the breadth of the Trust's services. Despite the amount of work that goes into this preparation, the papers are not always effective at helping to give the board an understanding of how maternity and neonatal services are currently performing and the challenges that they are facing. This is critical for boards to be able to fulfil their role and to drive a culture of learning and improvement.

Some of the key findings included:

Varying coverage of data presented through local dashboards: Despite the list of minimum data measures for Trust board overview set out in the Revised Perinatal Surveillance model[xiii], the data included in board papers varied widely.

Compared to the minimum metrics:

- Nearly all Trust (6 out of 7) consistently included mortality data in reports to the board; however, none reported against the ambition to halve mortality rates in England relative to 2010 rates.
- All Trusts reported the number of serious incidents and most (5 out of 7) reported the number of incidents graded moderate harm or higher.
- All Trusts reported on their compliance with the Maternity Incentive scheme – which also covered compliance with other national initiatives such as the Saving Babies Lives' care bundle.
- Most Trusts (6 out of 7) reported on the number of cases which were referred to HSIB and 4 out of 7 Trusts reported themes and lessons from external sources including the HSIB, Perinatal Mortality Review Tool (PMRT), CQC and NHS Resolution. Trust 5 included the top five themes from PMRT and HSIB reviews in every maternity dashboard.
- Most Trusts (5 out of 7) reported on safe staffing levels, and the remaining two presented some staffing data. Fewer Trusts reported staff feedback – only one included a detailed review of the NHS staff survey for midwifery and two included detailed staff feedback from other sources.

This variation means that boards are not consistently being presented with the key metrics which NHS England has suggested to provide an overview of maternity and neonatal service performance.

A wide range of additional metrics are reported by many Trusts, without explanation: Related metrics are not clustered together e.g. grouping public health data (e.g. smoking at time of delivery); morbidity data (e.g. 3rd degree tears); mortality data or operational data, which could help the reader understand what message(s) the disparate metrics are offering. The inclusion of some metrics, such as caesarean section rate and induction rate, and the implication for service safety and quality may require further explanation.

Large quantities of hard to digest information: The board papers were typically long and detailed, with many presented in one pdf document. This creates issues with readability and navigation. Some reports to the board included large quantities of repeated information with only short regular updates which are not clearly signposted. For example, reports on progress against the immediate and essential actions recommended by the Ockenden review included several pages of background information related to the review which was repeated in each report rather than provided as supplementary information. This makes it hard for the reader to identify the relevant updates that require their attention. Most Trusts (5 out of 7) also had reports which included charts or diagrams which were not legible.

Data and intelligence are spread across multiple reports: This makes it hard for board members to have oversight of what is going on in maternity and neonatal services.

Lack of analysis for board to understand trends or detect early warning signals: Although some papers included trend analysis or RAG ratings, reports included little to no additional analysis to draw attention to metrics or trends which might suggest the services are off-track or declining. Clinical service leaders have the knowledge to be able to contextualise the data and help board members to understand the implications. However, from the reports we reviewed it appeared that this knowledge was not currently translating into the submissions to the board. Board Assurance Frameworks are one opportunity for risks to be flagged to board members; however, the matrixes can place equal weight on patient safety, reputational and financial risks.

No data on health inequalities: Despite the stark and persistent inequalities in pregnancy outcomes according to ethnicity and areas of deprivation nationally, there was no data or information on inequalities at Trust level. While trends in mortality data can be harder to identify at Trust level due to the small sample size, there was no discussion of experiential or operational data according to different demographics.

Variable coverage of external data and reviews: Few board papers included external data, such as from NNAP, MBRRACE-UK or the Office for National Statistics (ONS). While most dashboards used local data systems to provide mortality and clinical data, external data is an opportunity to review progress annually against the national target in England and to discuss other themes such as health inequalities. Many papers included the number of cases referred to HSIB, PMRT and other reviews; however, only a few provided any insights on the findings from the reviews. This prevents the board from having oversight of any recurring issues.

Robust and candid review process

The minutes of public board meetings show that discussion of the papers related to maternity and neonatal services was often limited during board meetings. Papers are often noted for approval without discussion or refer to more detailed discussions which have happened elsewhere.

Some of the trends identified included:

Short, allocated meeting time often spent presenting the reports: Trust boards review information from across the Trust which makes focusing on particular services challenging. Across the meetings reviewed, agendas allocated between 5–30 minutes to discuss maternity services. Often, although not always, meeting time was spent presenting messages rather than discussing the implications. For example, Trust 1 allocated 15 minutes for the East Kent Report and the Maternity Services Update report – both items were noted by the board without discussion.

Detailed discussions happening elsewhere: Sub-committees, such as Safety and Quality Committees, appeared to discuss service performance in more detail. However, reports to the board often referred to "actions" or "themes" emerging from discussions but with no further details. For example, in relation to rising neonatal infection rates in Trust 1, the board papers noted that "No single cause had been identified but actions were being taken to address areas identified by the review." No further detail was provided on some of the issues or mitigating actions which had been agreed. This lack of detail makes it hard for boards to identify common themes between different reports or reviews, or issues from across the Trust.

Variable scrutiny from board members: Just over half of the Trusts which were reviewed (4 out of 7) had limited discussion of the maternity and neonatal reports. However, this was not the case for all boards. Board members in Trust 2 were particularly engaged – citing recent national reports or statistics and asking how the Trust performed in relation to those concerns. This board also showed engagement and curiosity where metrics were positive – for example, noting "the majority of indicators are showing green and queried if there were any areas of concern."

Visibility of NED maternity champion: Some board minutes noted NED maternity champion activities including ward visits, chairing committees and attendance at monthly Maternity Surveillance groups (e.g. Trust 3) and insights which NED maternity champions were able to provide (e.g. Trust 6). However, this role is not uniformly positive or visible – for example, the board safety champion was not identified in the papers or minutes for Trust 5 and did not appear to provide additional context or challenge to the reports presented to the Board.

Early action to address concerns

Mitigating actions were not decided by board members: While some board members did ask questions or for further information, no actions were decided by board members. More often the reports included mitigating actions which had been decided by the services themselves, although boards did not offer much scrutiny as to whether they were sufficient or request updates on previous actions.

Questions or clarifications are rarely revisited: When board members do ask for clarifications, updates were rarely followed up on. The threshold to adding an item to an action log appears to be high as very few comments result in a new action. This means that legitimate questions are not publicly responded to.

Conclusions and policy implications

This review raises questions about Trust boards' ability to deliver the level of oversight and scrutiny that is currently expected of them. Boards typically meet every two or three months to review large amounts of information from across a wide range of services which limits the time available to engage with the performance of maternity and neonatal services specifically.

Our review has highlighted the following policy and practical needs:

Guidance on the minimum metrics to be submitted to boards: Clearer guidance on the minimum metrics required by boards should be developed and socialised with Trusts. Minimum metrics should include any new measures identified by the Maternity and Neonatal Outcomes Group[xiv] to provide an early warning of service quality and safety declining.

Better ward-to-board communication is required to contextualise data and findings: Effective monitoring of services requires familiarity with services and data. This requires integrating more insights from Clinical Service Leaders in reports to the board to contextualise the metrics presented, as well as board members' engagement with wards and staff.

Reports to the board should include reviews over a longer time frame: While dashboards are critical to ongoing monitoring of services, there is also a need to step back and reflect on metrics and trends over a longer time frame. This could include reporting on external metrics from MBRRACE-UK, NNAP or others, progress against national targets, or recurring issues highlighted by external reviews (e.g. PMRT, HSIB).

Review current systems and processes in each Trust and whether they allow boards to have meaningful oversight over the quality and safety of services: The data and intelligence that is provided to boards must be used to take meaningful action to improve services. Given the breadth of topics board meetings currently include, there is a lack of time for meaningful scrutiny and discussion. Without this scrutiny, there is a risk that reports to the board become tick-box exercises which do not paint a true picture of service performance and are not used to identify required mitigating actions. There is a need to review the meeting frequency and/or length to ensure sufficient time for meaningful scrutiny or to delegate this scrutiny further, alongside improved transparency of committee-level discussions.

Transparent reporting of the issues discussed outside of public board meetings, such as at sub-committee level: It may be necessary to delegate some scrutiny to sub-committee level but reporting to the board needs to synthesise the issues and risks that are discussed, rather than reporting that discussions have taken place. This fits into the wider need for more transparency, which is core to a culture of learning and improvement. All too often boards appear to seek comfort from reports rather than encouraging open and honest reporting of problems.

Review the maternity incentive scheme: There is a need to review the extent to which the maternity incentive scheme in its current form incentivises transparent reporting of performance issues so that they can be addressed in a timely way. There is a risk that the boards and services focus on demonstrating compliance with the scheme rather than supporting the improvements in safety. Without a system which incentivises transparent reporting and provides support for areas of need, Trusts may prioritise financial certainty and reputation management over a culture of learning and improvement.

Clarity over the role of LMNS: Local Maternity and Neonatal Systems (LMNS) were created in 2016 following the recommendations made in the Better Births Report[xv] to bring together providers of services in the same local areas. LMNS are asked to measure progress on reducing stillbirths, neonatal death, maternal death and brain injuries, as well as promoting personalised care and choice amongst other measures. More clarity is needed over what this oversight means for Trust boards' responsibilities and how the two governance systems intersect.

While our findings relate to Trusts in England, other reports from across the UK nations have noted similar challenges. An Independent Review of neonatal services at Cwm Taf Morgannwg University Health Board in Wales[xvi] found that board assurance of safe services was based on an absence of safety issues that were escalated to board level, rather than evidence of a safe and efficient service and recognised the need to improve "ward-to-board" assurance processes. These commonalities suggest that there is an opportunity for all the devolved health services to review and improve board oversight processes.

Appendix 1: Reporting framework

Name of Trust	
Trust comparator group[1]	
Date of review	
Review period	

Board reporting

Person responsible for reporting to Board	
Local maternity and neonatal dashboards	
Discussion of external mortality data (MBRRACE-UK)	
Reporting of serious incidents	
Discussion of external reviews (PMRT, HSIB)	
Maternity / neonatal improvement programmes	
Staffing	
Other	

Board actions

Board oversight	
Actions agreed to remedy issues identified by reviews (PMRT, HSIB, Serious Incidents)	
Board review of agreed actions	

Metrics of Trust performance

MBRRACE-UK (Rates stabilised & adjusted)	
National Neonatal Audit Programme (NNAP)[1]	
CQC	

1. Five metrics reported by NNAP are:
   - Mothers who deliver pre-term (24–34 weeks gestation) and were given any dose of antenatal steroids
   - Mothers who deliver babies below 30 weeks gestation given Magnesium Sulphate in the 24 hours prior to delivery
   - Babies <32 weeks gestation who had temperature taken within an hour of admission that was between 36.5°c and 37.5°c
   - Documented consultation between parents/carers and a senior neonatal team member within 24 hours of admission.
   - Babies <32 weeks gestation or of very low birthweight who received appropriate screening for retinopathy of prematurity (ROP)

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