

**Trust Board**

**TB2008.37**

From: Ms Amanda Middleton, Acting Director of Operations, Division C  
Date: May 2008  
Subject: **Safe Birth - Kings Fund report on recommendations for Trust Boards**  
For: **Information**

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**Synopsis**

The Kings Fund has published recommendations on patient safety, including their conclusions from a year-long enquiry into the safety of maternity services. Their conclusions address the role of trust boards and the need to raise the priority of maternity services at Board level. Trust Board is asked to consider their conclusions, and advise the Executive of any matters they wish to be further considered at the ORH.

**Financial, legal and risk impact**

The cost of litigation for cases related to maternity services is increasing each year. A Trust-wide focus on understanding risks and improving safety in maternity services can lead to a reduction in cost.

## 8 Safety – the trust board’s primary responsibility

### Overview

The first duty of health care organisations, as of health care professionals, is to do no harm. This obligation is particularly pressing in maternity care, where errors and accidents have the potential to cause severe damage, with lifelong effects on women, children and families. Meeting this obligation is central to the tasks of trust boards and has important implications for how they conduct their business.

### FORMAL RESPONSIBILITIES OF NHS TRUST BOARDS

The board’s role is to lead the organisation as a whole, taking corporate responsibility for *all* activities and risks, not just some of them.

The board’s key tasks are strategic: the board determines the organisation’s strategy and priorities, monitors progress against objectives and manages financial and other risks, including clinical risk. Effective boards actively manage communications so that patients, the wider community, staff and partner organisations understand their objectives and priorities.

The complexity of modern health care organisations makes the job of trust boards very challenging. Health care in advanced societies is highly specialised, technical, fragmented, subject to growing demands, and expensive. Organisations providing health care are under immense pressure and their boards have to balance patient care against responsibilities to staff, the wider public, the public purse and government.

Because organisations take their character from the top, the actions and decisions of the board influence the culture of the entire organisation. The issues prioritised by the board communicate an important message to staff about the values of the organisation. When boards take an active interest in the quality and safety of clinical care and the experience of patients and families, their involvement is known to contribute to staff morale. Board members are uniquely placed to look across the organisation, to challenge silo working and to spread best practice.

*In general there is strong correlation between the quality of the leadership by the Chair and the Chief Executive and the success of the NHS organisation. Conversely, where an organisation is not delivering, questions can legitimately be asked about the quality of the board leadership.*

(NHS Appointments Commission 2003)

### BOARD RESPONSIBILITY FOR PATIENT SAFETY

In most industries, especially service industries, it is taken for granted that the board has ultimate responsibility for the quality of the goods and services the company produces. In the NHS, however, boards have been responsible for the quality of health care for less than a decade, beginning with the passage of the 1999 Health Act.

This Act gave boards a statutory duty ‘to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care which it provides to individuals’; and it made the chief executive, as the accountable officer, personally responsible for the so-called ‘duty of quality’. In 2001, following government acceptance of the Chief Medical Officer’s report on patient safety, *An Organisation with a Memory*, the board remit for quality was articulated to include patient safety explicitly (Department of Health 2000).

The structure through which boards discharge their responsibility for quality and safety is the health care governance committee (previously the clinical governance committee). Non-executive directors (NEDs) are not obliged by statute to sit on these committees, but in many trusts they do, and some of these committees have non-executive chairs.

Chief executives cannot delegate their accountability for patient safety, but most chief executives delegate executive responsibility for safety to one or other of the clinical directors on the executive team. All trusts have a board director responsible for patient safety: in most cases the director of nursing (47 per cent) or the medical director (32 per cent) carries this responsibility but in some trusts (11 per cent) it is carried by the chief executive (NAO 2005).

Nursing and medical directors have dual responsibility for patient safety, both as NHS executives and in their professional capacities as members of the register of the Nursing and Midwifery Council or the General Medical Council.

### **BOARD MEMBERS**

In all sectors, non-executive and executive board members have different responsibilities. A small minority of non-executive directors on NHS boards, including a few chairs, are health specialists, but most are lay people.

The chair of the board is expected to spend more time with the organisation and to work more closely with the chief executive than the other non-executive directors. The chair's role is to develop and run an effective board, so they must make sure that:

- board agendas reflect the full range of corporate activities, risks and responsibilities
- board members understand their responsibilities and have the necessary information to discharge them
- discussion is open and constructive.

Effective chairs summarise key points, confirm decisions and make sure the board's priorities and concerns are communicated throughout the organisation.

Non-executive directors are generally less close to the organisation, their role being to represent the interests of patients, taxpayers and the public and to challenge senior executives when necessary. Non-executive directors help to determine strategy and must assure themselves that the organisation makes progress against its objectives and manages financial and clinical risks effectively.

As the most senior employees of the organisation, executive directors are responsible, both individually and collectively, for:

- the achievement of corporate objectives
- all operations and performance
- financial and clinical risks
- relationships with stakeholders.

### **Problems with trust boards**

#### **LOW PRIORITY FOR MATERNITY**

Respondents to our inquiry suggested that boards give insufficient priority to safety in maternity services. Some ascribed this failure to national factors, including an absence of measured targets.

*The National Service Framework sets an expectation of quality of service but does not define exact parameters or indicators of outcome. Standards of care and service defined by the RCOG/RCM and NICE are not enforced and, as a consequence, resources in some trusts have been withdrawn from maternity care to cover costs required to meet defined and monitored targets elsewhere in the trust.*

(Written evidence, HCC)

Low priority for maternity services was also blamed on a lack of effective advocacy for maternity on trust boards. In most boards, discussion of maternity services is led by the director of nursing, and in 50 per cent of boards this director also leads discussion about quality and safety. However, there is evidence that directors of nursing are not powerful advocates for the 'business of caring' and often struggle for influence at board level (Burdett Trust for Nursing 2006a).

*There are examples of exceptional clinical leaders who have succeeded in making patient care a driving force in their organisation's strategy and operational processes, but they are in short supply.*

Many people working in or connected with maternity services believe that current representation on boards does not allow the case for these services to be presented powerfully.

*Low and decreasing investment in maternity services is a reflection of how maternity services have a lower status. Increasing the direct representation on the boards of acute trusts could play a role in this. At present an obstetric lead and the director of nursing sit on each trust, but there is no head of midwifery: instead midwives are represented only by the director of nursing.*

(Written evidence, National Childbirth Trust)

*The voice of midwifery is not heard at trust board level due to a lack of senior midwifery representation. Maternity issues therefore do not become trust priorities. Maternity services appear to be a low priority in a target-driven NHS.*

(Written evidence, Royal College of Midwives)

Given the size of trust boards and the complexity of NHS organisations, which employ many different staff groups in a host of specialties, it is difficult to make a case for board representation for any particular specialty or professional group beyond the generic groups of medicine and nursing. Boards function at a high level and their members should be able to exercise their scrutiny and assurance functions across all the trust's directorates and services, with the support of reliable systems and with access to expertise in specialist areas, like midwifery, when they need it. However, the special nature of maternity services (where a normal physiological process can escalate into an emergency with very little warning, and where the consequences of safety failings can be far-reaching) calls for particular scrutiny of safety.

Those representing maternity services to the trust board need to present accurate, timely data on a small number of critical measures, showing trends, tracking performance over time and supported by an intelligible commentary. Board members need to be made aware of the limitations and gaps, as well as the strengths, of the data and should have access to help in interpreting it; they need to understand the strategic importance of the clinical service and to see it in the round; they should see measures of cost, volume, clinical outcome, clinical risk, efficiency, quality, patient experience, activity, and staffing.

However, most boards do not receive a good set of performance measures for review regularly and do not even appear to know what information about maternity services or patient safety would be most useful. As the HCC observed:

*Inadequate IT or insufficient expertise to interpret and use management information may result in difficulty in securing greater investment in resources; traditionally clinicians do not routinely explore how the board makes decisions and how to make the case, but instead may use evidence of research without any financial or performance information to secure appropriate resource in the competitive climate of a target-focused trust.*

(Written evidence, HCC)

Trusts vary in the extent to which maternity incidents and major near misses are reported

to the board. Changes to the process for handling complaints also make boards remote from safety issues. Unresolved complaints used to be reviewed by a trust non-executive director acting as 'complaints convenor', and this meant that major complaints had board-level scrutiny at all trusts. However, all complaints are now dealt with centrally by the HCC, and so board-level exposure to safety issues has now been lost. Complaints handling is likely to change again, though, with the introduction of the new Care Quality Commission.

Maternity services are often located within the women's and children's directorate, which may further reduce visibility to boards because data on maternity services is subsumed within a broader set of information. Furthermore, boards are not usually aware of the cost of maternity settlements made on their behalf by the NHS Litigation Authority (oral evidence).

### **POOR FOCUS ON SAFETY**

The Department of Health itself has drawn attention to this problem.

*The NHS is now well aware of clinical governance, but there is substantial variation in the extent to which the concepts that it embodies have become embedded within the everyday fabric of the NHS teams and organisations. In places, adoption has not progressed beyond the structures of clinical governance: such structures are necessary but not sufficient.*

(Department of Health 2006)

This, in our view, is a more pressing problem than the lack of effective representation of maternity services. NHS trusts are in the process of developing safety cultures, but at this stage most trusts are 'reactive in their approach to patient safety, only taking action following an incident or near miss'. Only a few boards think strategically about patient safety, making connections between safety, the organisation's corporate objectives and its priorities in relation to finance, market share, workforce or service configuration. Only a minority of boards carry out cost benefit analyses of interventions to improve patient safety (NAO 2005).

The HCC's latest annual assessment of NHS trusts' compliance with the Department of Health's Standards for Health shows that four of the six standards with the lowest compliance rates are directly related to patient safety. Lack of compliance is most frequent in:

- a systematic and planned approach to records management
- participation by health care staff in mandatory training
- ensuring that the risk of health care associated infections to patients is reduced
- ensuring that reusable medical devices are properly decontaminated prior to use.

The inquiry heard that boards pay relatively little attention to patient safety or to maternity services, or to safety in maternity services. The reasons for this relative neglect are difficult to disentangle.

Paradoxically, despite the fact that the core business of the NHS is health care, trust boards pay relatively little attention to clinical matters, including patient safety.

*Overall 14 per cent of items in meetings were rated as clinical but [this] varied between 7 per cent and 22 per cent over the year for different trusts. Trusts with higher levels of clinical issues discussed seemed to have a chief executive officer who ensured that clinical issues were closely linked to all trust developments, including finance and information.*

(Burdett Trust for Nursing 2006b)

There are probably many reasons for this.

- Non-executive directors and non-clinical executives may feel that clinical work is specialist and technical, best left to the experts. They may feel more comfortable with

non-clinical areas that are familiar and where they can make a more significant contribution.

■ There is intense pressure on chairs and chief executives, from the Department of Health, strategic health authorities (SHAs) and primary care trusts (PCTs), to focus on financial health and national targets. Several of the written submissions we received gave this as an explanation of the failure to prioritise safety.

However, these pressures cannot fully explain the failure of boards to make safety their prime concern. For one thing, financial health is not inimical to safety – quite the reverse, in fact; for another, there is a national target for lowering rates of hospital acquired infection. However, even in this one area of patient safety that has a national target, backed by massive public and media interest, boards may fail to pay sufficient attention. This was a key finding of the HCC's investigation into the recent outbreak of *C difficile* at Maidstone and Tunbridge Wells (Healthcare Commission 2007).

In our view, the reasons are twofold, and linked: the first is a lack of confidence by board members in dealing with what is often perceived as a 'clinical' issue; the second is lack of good information about safety.

When a board manifests discomfort about treading on clinical territory or finds compelling reasons to focus attention elsewhere, clinical services without national targets and patient safety need a powerful advocate on the board to ensure these issues gain a place on the board agenda. 'Within local organisations, strong leadership and governance at chief executive and board level is crucial' (National Audit Office 2005).

Every member of the board should be an advocate for safety. As 'current concepts of patient safety place prime responsibility for most adverse events on deficiencies in system design, organisation and operation', board members need to understand how frontline clinical services work and what can go wrong (Department of Health 2006). With the exception of some clinical directors, only a minority of members join NHS boards with an adequate understanding of what is required of them in relation to managing clinical risks and patient safety. As they must acquire that knowledge on the job, what is the best way to do this?

Regrettably, the information that reaches board members about the safety record in their own trusts is often limited. There has been a general increase in the number of incidents reported, but in cases of severe harm, the level of under-reporting is thought to be relatively high (NAO 2005). At least one in five incidents in which a patient has suffered severe and permanent harm or where a patient death reflects unsafe care goes unreported, and the board members will not be told.

Boards can extend their collective knowledge of frontline services and of safety issues if senior executives report back regularly on what is happening 'on the ground'. In some hospitals, the directors of nursing and senior nurse managers, including the head of midwifery, spend a day every month in uniform, working alongside clinical staff, to deepen their understanding of the experience at the front line. More often, though, senior executives are remote, inaccessible and ill-equipped to enlighten the board (Smith and Dixon 2008).

*We have never seen our chief executive in the maternity unit. A high-profile visit would improve morale and help us to take forward initiatives we have developed.*  
(Professional evidence, midwife)

### **Barriers to prioritising safety**

This is not the first time boards have been criticised for failing to prioritise safety or maternity services (see, for example, Healthcare Commission 2005, 2007). However, the inquiry is aware that boards still do not make patient safety, including the safety of women and babies who use their maternity services, a top priority. It seems important to ask why.

Trust boards are like any other group of people who share a common task. They are a team – potentially, but not always in practice, an effective team. To work effectively, they must agree on the nature of the task, learn how to work together and gain an understanding of their own and others' roles. Board members do not automatically know how to work together: they are always under pressures of time, the information they receive is often poor and there are inevitable tensions and conflicts; people have different opinions about the task, different interests are represented at the board table and board members have different levels of knowledge, expertise and confidence.

Non-executive directors may lack confidence, while executives may find it difficult to listen to people who know less than they do. This tension may be exaggerated in discussions about clinical care and patient safety, which seem to require specialist knowledge. On an individual level, some people are more articulate or more persuasive than others.

Boards work well when everyone contributes to the discussion, when non-executive directors challenge executives confidently and when executives cope with being challenged. Like any other group with a common task, the board needs to take some time to look at itself and how it works, to reflect on what does and does not go well and to learn lessons from experience. It is for the chair and chief executive to make sure this kind of reflective activity happens relatively often. Outside formal board meetings, with or without the help of an external facilitator, boards and individual directors need to make time to understand their own and others' roles in relation to their task, and must learn not to evade conflict through silence.

*In trusts with higher levels of clinical content, non-executive directors seemed to question and interrogate trust board executives in an open and transparent manner. For example, in one acute trust, when non-executive board members asked for further information on clinical governance and service improvements, the chief nurse produced appropriate information at subsequent meetings.*  
(Burdett Trust for Nursing 2006a)

Everything about how the board operates, including the conduct of directors, the relationships between them and how they are seen to interact, sends a message to the staff about what matters in the organisation. Boards are teams too, and if they are to discharge their responsibility for safety effectively, they need to become effective teams.

## Solutions

Leaders of NHS organisations face huge challenges in balancing competing priorities in a climate of intense media and political scrutiny. However, they have the potential to bring about significant improvements in patient safety and should be able to do so with the right tools and support. A high-performing board must prioritise safety, and the chair and chief executive should work together to ensure safety has equal weight with other priorities on the agenda.

### **EDUCATING THE BOARD IN PATIENT SAFETY**

If they are to monitor safety effectively, board members need structured opportunities for educating themselves about safety issues and improvement methods. A variety of such opportunities are available, including external training programmes, in-house away days, seminars and workshops. One powerful exercise for a board is to make time, at regular intervals, for in-depth examination of a specific safety incident that occurred in their own hospital, ideally inviting staff involved to take them through a root cause analysis. Some boards are open enough to invite patients and relatives to take part in such discussions, so actively modelling a commitment to learning from experience and making the necessary changes to prevent similar incidents in future.

### **SAFETY IN A BUSINESS MODEL**

Changes in the nature of health systems in England mean that NHS trusts are increasingly looking to a business model for management and governance of their operations. It might

appear that safety would struggle for priority in a financially driven organisational climate. However, we would argue that the reverse should be true because with all successful businesses the quality of the product is a key consideration – and unsafe health care is not a high-quality product.

If in future there is increasing competition for patients, boards will need to understand the reputational risk of safety lapses (especially in maternity care) and the damage these will do them in a competitive market. They also need to see the business advantages of having solid data about the safety of their maternity unit, which may attract patients away from other trusts, whose safety data are less compelling. Boards need to be aware of the marketing value of a successful maternity unit in an era of patient choice. For most women, giving birth is their first adult contact with a hospital; if that experience is a happy one, the hospital may well be the health care venue of choice for that family for decades to come.

Apart from performance information about the safety of maternity services, another measure that may be useful to the board is the number of mothers within their catchment area that are electing to attend a different hospital. Boards in receipt of this information would be more likely to focus on maternity, as well as gaining evidence of how the hospital is viewed in the community by the 'customers' of the future.

The move to service line reporting may help to reinforce priority for maternity services by ensuring that they are seen as 'businesses' in their own right.

### **INFORMATION FOR SAFETY**

It is vital for the board to have the right information, and every meeting should start with consideration of a balanced scorecard, on which safety indicators are prominent and specific maternity indicators included. The safety indicators should be aspirational and set within a context of international best practice if the trust is already exceeding national averages. The board should also receive information on the cost of settlements made on its behalf by the NHS Litigation Authority and on the average levels of settlement made on behalf of all trusts. Such information would invariably be dated but would be sufficiently arresting to warrant regular attention.

The balanced scorecard is a tool that provides high-level information on all aspects of a trust's business. Underneath this, the board should agree a more detailed 'dashboard' of measures it will use to review the performance and safety of maternity services. These could include outcomes, activity, workload, staffing levels, training, intervention rates, near-miss incidents, risk incidents and complaints, and should be supplemented at intervals by data from staff and patient surveys. Measures of clinical risk can be integrated with trust-wide risk registers.

#### **DEVELOPING A BALANCED SCORECARD FOR SAFETY AND MATERNITY**

The balanced scorecard is an approach to managing and measuring performance in four domains. The domains defined are: financial, customer, business process, and learning and growth. Specific performance measures relating to each domain can be developed by individual organisations according to their needs and circumstances and with reference to the following questions.

- **Financial** To succeed financially, how should we appear to our stakeholders? (In the public sector, the financial perspective tends to emphasise cost efficiency.)
- **Customer** To achieve our vision, how should we appear to our customers (patients)?
- **Internal business processes** To satisfy our stakeholders and customers (patients), what internal processes must we excel at?
- **Learning and growth** To achieve our vision, how will we sustain our ability to change and improve?

We would argue that a balanced scorecard must include safety indicators. In the financial domain we would expect to see information on litigation premiums as well as on actual claims. The customer perspective would draw on information from surveys of women. Business processes that contribute to the achievement of high levels of safe care would be monitored in the third domain. Outcomes indicators as well as process measures

could be included. Finally, indicators of an organisation that learns and grows would be included in the final domain. This might include staff training, promoting multidisciplinary working, etc.

Source: NHSWorkforce Scorecard Team 2006

The clinical governance committee or health care governance committee should use the same dashboard but may wish to add measures that offer greater insight into the more detailed operational matters relevant to quality and safety. Following the maternal deaths at Northwick Park Hospital, the RCOG produced a dashboard of performance and governance measures for governance committees (see Table 4, overleaf). Boards might wish to use this model or adapt it for their own purposes.

Given the human and financial costs of errors and accidents in maternity services, we believe that safety and risk in these services should be explicitly highlighted in trust-wide governance arrangements, and reported to the board rather than delegated downwards.

### **COMMUNICATING THE IMPORTANCE OF PATIENT SAFETY**

Boards need to convey the importance they attach to patient safety clearly to all clinical teams working in the trust, reinforcing the message regularly in emails, posters, management meetings, cascade briefings, newsletters and personal discussions. We were told that positive messages (such as 'we are improving... beginning to show progress... to be praised for...') were more effective than negative ones. Boards should take every opportunity to demonstrate to managers and staff that they take their responsibility for patient safety seriously and expect colleagues to do the same.

### **ADVOCACY FOR MATERNITY AND FOR SAFETY**

Chairs and chief executives must ensure productive discussions about maternity safety at board level. Those leading discussions must be knowledgeable, equipped to present key issues intelligibly and able to direct the board's attention to the critical issues. It may be a good idea to invite the senior obstetrician and head of midwifery to address the board at regular intervals. The board should require finance staff and general managers to work with clinicians in order to engage with relevant issues, solve problems and present a rounded picture of the service.

*When a really effective general manager works alongside a head of midwifery and a clinical director, you see how they can really work well and produce good data and information to influence the board to talk about staffing levels and so on; there's a kind of structured approach to how they make their case.*

(Oral evidence)

### **STRENGTHENING SAFETY COMMITTEES**

Safety must be a key focus of the main board, and maternity must be sufficiently visible within that focus. We heard that delegating issues to a subcommittee may reduce the priority attached to them. However, it may be unrealistic to expect large trusts to consider maternity at every board meeting, and giving them an annual paper to consider is not the best solution either. What the board needs is assurance about the quality of the maternity service, with the ability to drill deeper into appropriate issues as necessary.

Having an effective health care governance committee, constituted as a subcommittee of the board and chaired by a non-executive director, to provide assurance on safety matters can play a valuable role in setting the tone on safety to the organisation as a whole. With sufficient influence and board backing, such a committee can have a real impact on matters of clinical quality.

### **EXECUTIVE SAFETY WALK-ROUNDS**

One of the most effective ways to promote communication between board members and frontline maternity staff is for executive directors to conduct 'safety walk-rounds'. We recommend that trust boards should require the chief executive and the director

responsible for safety to do this at regular intervals, with formal reports back to the board on lessons learned and actions taken.

With a safety walk-round, executives spend time – either separately or in a group – talking with staff in various care areas about safety incidents. By making time for this activity, they send out an important message about the value the board attaches to patient safety, as well as demonstrating support for frontline staff. Directors can use the safety walk-round as an opportunity to see for themselves how the care systems work and to correct defective processes. They can also gain insight into the unquantifiable interpersonal and human factors that contribute to system safety, including:

- the quality of communication within and across teams
- levels of trust and openness between staff
- relationships between senior and junior members of staff
- staff awareness of the safety record of the department
- staff morale.

(Institute for Healthcare Improvement 2007a, 2007b)

One national organisation that had worked with trusts with safety problems described the difference visibility can make.

*The way the board engaged with work of the unit was, I think, developed into a very good model. They were visible, they took an active interest in what was happening and there were regular reports from that service to the board.*

(Oral evidence )

## CONCLUSIONS

Trust boards have a fundamental duty to safeguard the patients for whom their staff provide care. In other industries, lack of concern for safety at board level would be regarded as negligent. Yet this seems to be tacitly accepted within health care, where the potential for harm is usually much greater.

The analogy with business is revealing. In business, the quality of the product is critical to its success: a trust's key product is how safely it cares for its patients. Boards should therefore demand rigorous, routine information on safety from maternity units (as indeed from other units) and should support the collection of this information. In our view, failure to do so constitutes failure to discharge a statutory responsibility. Safety must never be delegated to a subcommittee without non-executive director membership. Safety information should form part of the balanced scorecard of key performance indicators that should be the first agenda item on every board meeting. Trust boards also need information from the NHS Litigation Authority (NHS LA) on the cost of settlements of clinical negligence claims made on their behalf.

## Recommendations

Boards should take the following steps to improve safety.

- Prioritise safety, communicate that priority to staff and patients and make data on safety publicly available.
- Educate board members about safety issues in maternity services and strengthen advocacy for maternity safety on the board.
- Have governance structures in place to assure safety, including strengthening safety committees and systems for collecting and reporting safety information.
- Improve their understanding of the safety issues in their trusts by means of regular executive walk-rounds, analysis of claims data, incident reports and other safety indicators, and by reviewing safety incidents in detail.
- Clarify the importance of safety as a business imperative.