NHS Resolution

Safety Action F – Board Oversight & Governance

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Board Oversight, Governance, Culture and Leadership: Safety Action F

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Outcome and minimum requirements for Safety Action F

The Trust Board has effective oversight of the quality and safety of their maternity and neonatal services.

Board Oversight of Maternity and Neonatal Quality and Safety

Board Oversight Responsibilities

Boards must routinely review comprehensive assessments of maternity and neonatal quality covering training, workforce, and user experience.

Formal Escalation Process

Findings from Quality Governance Committees 9or equivalent) must be escalated to the Executive Board to ensure full oversight and governance.

Regional Midwifery Escalation

Where Trust mitigation is insufficient, cases should be escalated to Regional Midwifery Officers with documented PQOM aligned actions.

- Maternity Outcomes Signal System
- Maternity and Neonatal Board Safety Champions
- Perinatal Culture Improvement Plan

Why is Safety Action F important?

Trust Board Accountability

Trusts are responsible for delivering safe, effective, and equitable maternity and neonatal services.

Reporting and Escalation

Through implementation and alignment with PQOM it facilitates an effective route for reporting, action and escalation

Underpins other safety actions

Strong focus on board accountability to ensure impactful improvements in perinatal safety and care quality.

Maternity Outcomes Signal System (MOSS)

David Robertson

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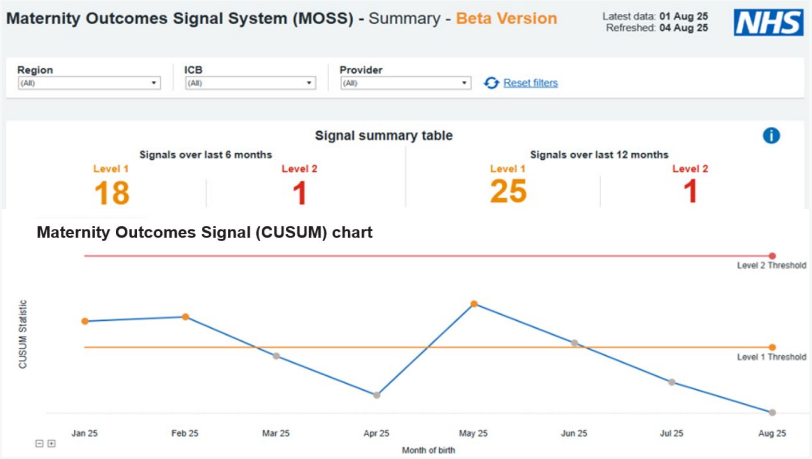
Background and purpose

Recommendation 1 of 'Reading the Signals': introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use

NHS England developed and piloted MOSS from 2023 – 2025, making widely available in November 2025 with published standard operating procedures.

Principles

- signal system sensitive and specific to services delivering **intrapartum care**
- use timely data to identify ***potential*** declines in safety processes for intrapartum safety - not an indicator of an unsafe service
- **prompts a critical safety check** led by the local perinatal leadership team
- support rapid escalation through Trust, ICB, regional, and national PQOM structures
- support a positive safety culture, improve trust and confidence of staff and families, and ultimately better outcomes



What is the ask for MIS Year 8?

- Trusts must evidence that the critical safety check (Annex 1 of the MOSS standard operating procedures) was completed in the event of signals, or that a test drill (Annex 9) was carried out if no signals occurred. An accountable trust board executive (i.e. Chief Nurse, Chief Medical Officer or Executive Trust Board Safety Champion) must approve completed checks, including drills. This will be externally validated through regional assurance – services must send a completed copy of critical safety check(s) or test drill to regions, for forwarding to the national team at england.moss@nhs.net

What is the ask for MIS Year 8?

What good looks like:

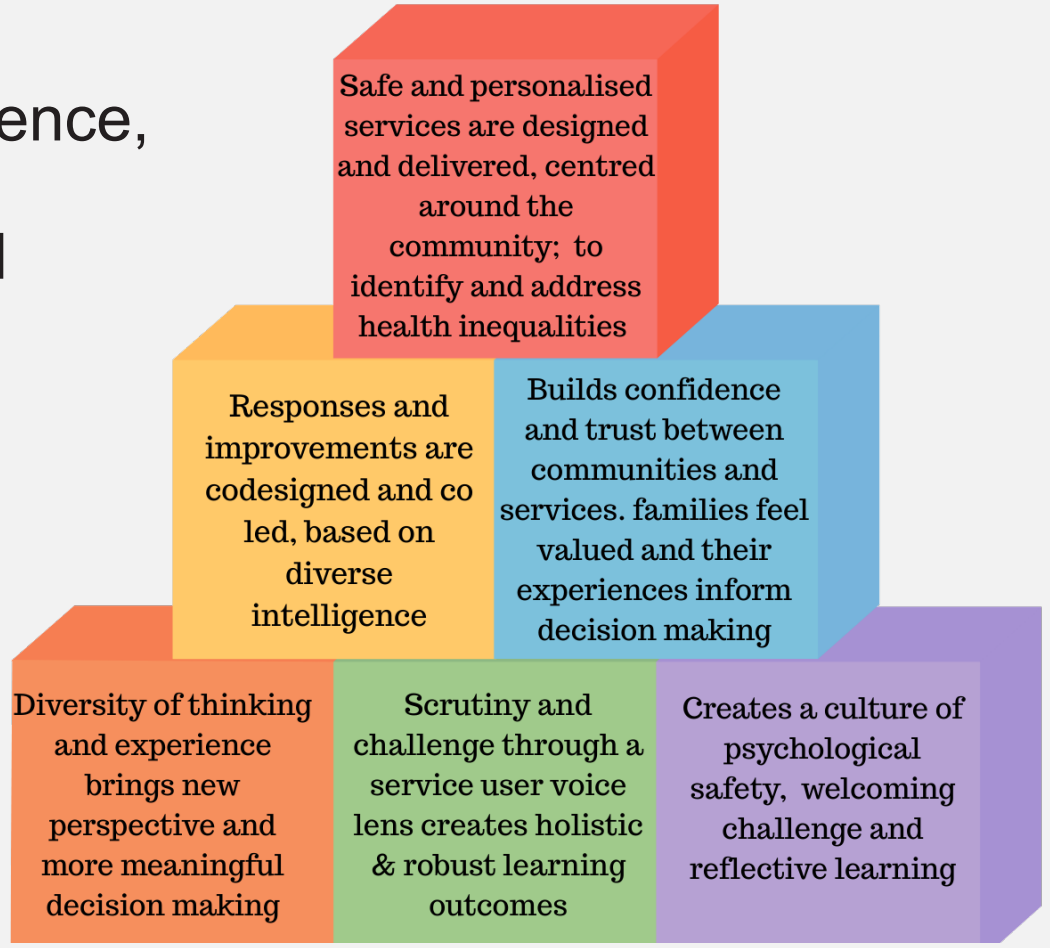
- A clear local process ensuring that whenever a MOSS signal is triggered, the critical safety check is promptly completed using the Annex 1 template, or a structured test drill (Annex 9) is undertaken as part of routine annual practice as per the standard operating procedures
- Completion of Annex 1 showing timely completion of checks or drills, with the responsible executive reviewing and approving each one, and their approval clearly recorded
- Checks and drills are not reliant on a single individual - perinatal leadership teams complete through co-production with staff working on the labour ward
- Routine submission of each completed critical safety check or drill to the regional chief nurse, midwife, obstetrician and medical director (as per the standard operating procedures), and the regional assurance team
- Perinatal leadership teams can arrange a meeting with the national MOSS project team at NHS England to discuss any aspect of MOSS. Half-hour slots are available on Mondays between 1.30pm-3pm. Please contact england.moss@nhs.net to arrange.
- Local governance oversight confirming that safety issues identified through MOSS checks are escalated for discussion to the next public trust board meeting for acting on
- Continued trust board oversight and active engagement to ensure changes or improvements are made at the required speed, with examples of these highlighted at trust board meetings.

Further resources available at Maternity Outcomes Signal System - Maternity and Neonatal Hub – Futures.
Trust colleagues responsible for maternity services can register for MOSS access via the NHSE Applications A-Z

Service user voice role – Safety action F

Provide independent insight into family experience, equity, communication and service design. Contribute to co-production of information and challenge governance discussions, ensuring service-user voice informs improvement.

Support transparency, learning and cultural improvement through shared leadership, collaboration and critical friendship.



What good looks like

- **Board oversight of Maternity and Neonatal Quality and Safety**
  - MNVP lead as part of PLT feeding directly into regular board reporting. Providing service user lens to risk escalation, action planning and service development.
  - Service user experience and intelligence central to board reporting
  - Service user involvement in oversight of reporting from safety actions A-E through governance and leadership processes

- **Maternity Outcomes Signal System**
  - MNVP lead has access to MOSS system as per SOP
  - MNVP lead part of critical safety check, feeding in service user experience to support meaningful actions

- **Maternity and Neonatal Board Safety Champions**
  - MNVP lead meets regularly with BSC alongside rest of PLT to share intelligence and escalate concerns
  - Walkabouts, engagement sessions with service user lead and BSC

- **Perinatal Culture Improvement Plan**
  - Perinatal culture improvement plan is coproduced and informed by service user experience
  - MNVP lead attends local, regional and national events and training alongside trust staff i.e ABC, PIER, Moments
  - MNVP involved in all improvement projects from the start using robust experience data to inform improvements

Useful resources

MNVP guidance (NHS England 2023)

Perinatal leadership team role descriptors (NHS Futures)

Perinatal quality oversight model (NHS England 2025)

MNVP collaborative assessment tool (London Maternity team)

MOSS SOP (NHS England 2025)

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NHSR Maternity (Perinatal) Incentive Scheme Board reporting workshop

Selina Dubison

Maternity Incentive Scheme Associate
NHS Resolution

Why the workshop was developed

Repeated national maternity reviews showed the same issues:

- Reporting was often over-reassuring, vague or overly positive
- Poor escalation, weak triangulation and missed early warning signals with opportunities for learning
- Boards did not always have clear oversight of maternity and neonatal safety

What this told us:

- Good work was happening locally
- But risk and opportunities for learning and improvement were not always understood at Board level
- Governance was a recurring failure point → The workshop was developed in direct response to this gap

Why this matters for maternity and neonatal safety

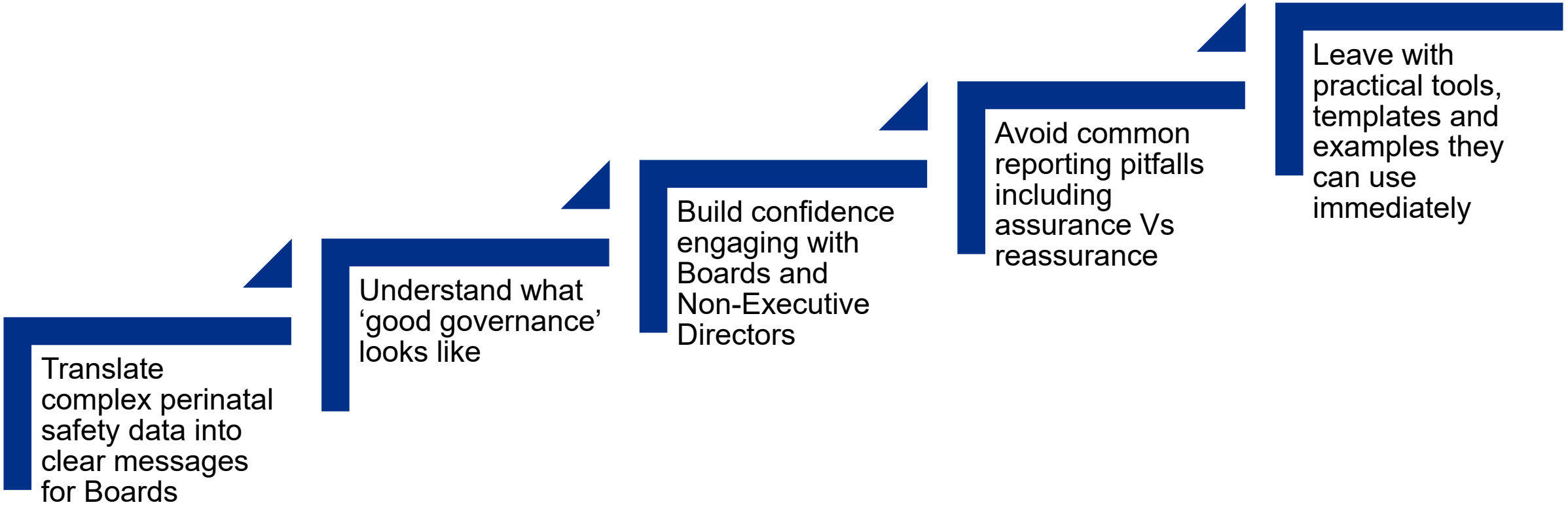
Board oversight, governance, culture & leadership

The workshop helps Trusts demonstrate clear assurance to Trust Boards that perinatal safety reporting requirements are being met across maternity and neonatal care

Focus:

- Unresolved concerns
- Escalation via PQOM
- Scrutiny
- Documented actions
- Assurance
- Governance oversight

Benefits from attending the workshop



Who can attend

- Trust Board members including Executives, NEDs and Board Safety Champions
- All maternity and neonatal staff (Midwives, Obstetricians, Anaesthetists, Neonatal staff)
- Perinatal leadership teams
- Regional, ICB and LMNS staff
- Organisations supporting perinatal safety improvements
- Any interested perinatal staff, especially those in risk or governance roles

Key take home message

The Board Reporting Workshop supports colleagues working in maternity, neonatal and governance roles to strengthen how activity, risks and assurance are presented to Boards, ensuring clarity of decision-making and accountability.

Organisational culture - how things really get done

It shapes behaviours, decisions, experiences and outcomes every day.

Why it's critical


Performance


Safety and Quality


Staff Wellbeing


Change


Trust and Reputation

Take home message:

"A positive culture is the heartbeat of safe, effective, equitable and personalised care. When we nurture respect, trust, accountability and openness, we better support women and babies, empower staff, and create space for joy in our work"