SPSP Caesarean Birth Change Package

2023 Caesarean Birth Driver Diagram

Healthcare Improvement Scotland | Scottish Patient Safety Programme

What we are trying to achieve…	We need to ensure…	Which requires…
Phase 1: Understand variation in caesarean births across NHS Scotland		**Phase 1**
	Understanding of variation	Accurate and complete Robson criteria data Understanding and use of NHS unit, board and national data Local data informs patient information and decision making
Which will then inform:		**Phase 2**
Phase 2: Identification of local improvement priorities	Person centred care* considers the Continuity of Carer approach	Women / birthing person empowered to make informed decisions about their care Shared decision-making between women / birthing person and healthcare professionals Inclusive care pathways which provide equitable and culturally appropriate access and treatment
	Safe communication*	A culture of open and effective communication within and between healthcare teams Multidisciplinary teamwork and collaboration
	Evidence based delivery of maternal care / fetal care	Safe, reliable care in labour Effective management of malpresentation and malposition Women / birthing person fully informed of induction of labour Effective management of VBAC
	Leadership to promote a culture of safety at all levels*	Psychological safety Staff wellbeing System for learning Safe staffing

Essentials of Safe Care

Core programme measures

Phase 1:
Understand variation in caesarean births across NHS Scotland

Which will then inform:

Phase 2:
Identification of local improvement priorities

Number of boards submitting Robson criteria data

Percent completeness of Robson criteria data

Number of boards using data to agree improvement priorities

Primary Driver
Understanding of variation

Secondary Drivers	Change Ideas					
Accurate and complete Robson criteria data	Staff education provided for Robson categorisation and data input	Raise staff awareness of missing data fields to improve accuracy				
Understanding and use of NHS unit, board and national data	Capture and share learning between boards	Identify focus for improvement work using CS data	Use of PHS coding algorithm to access Robson data	Robson classification data analysed and compared at national level	Demographic and ethnicity data analysed and compared at national and local level	
Local data informs patient information and decision making	Staff have access to and use local and national data to inform discussions using standardised discussion tool	Mechanism to measure quality of discussions and use data for improvement				

Primary Driver

Person centred care considers the Continuity of Carer approach

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Secondary Drivers	Change Ideas					
Women / birthing person empowered to make informed decisions about their care	Co-produced person centred care plans consider ethnicity, deprivation and individual communication needs	Documented individualised risk assessment for women / birthing people in latent phase of labour and in active phase of labour	Co-produced person centred care plan for women / birthing people in latent phase of labour and in active phase of labour	Person centred language is promoted and used (e.g. RCM Re:Birth) in all settings	Use of evidence based parent education and signposting to inform birth plans e.g. BRAINS / It's OK To Ask	
Shared decision-making between women / birthing person and healthcare professionals	Implement CoC model of care	Offer of specialist support for women / birthing people who have requested a planned CS	Documentation of shared decision making	Informed consent highlights the risk / benefits using evidence based practice and data		
Inclusive care pathways which provide equitable and culturally appropriate access and treatment	Social determinants addressed through onward referral to appropriate services	Staff afforded flexibility to provide care proportionate to need for those experiencing severe and multiple disadvantage	Staff able to identify, challenge and change the values, structures and behaviours that perpetuate systemic racism	Local education for staff to enable support for those experiencing severe and multiple disadvantage	Provision of timely interpretation services support	

Primary Driver
Safe communication

Secondary Drivers	Change Ideas				
A culture of open and effective communication within and between healthcare teams	Develop and implement effective lines of communication between community and hospital services	Post emergency caesarean section MDT debrief to provide opportunities for reflection and learning	Locally agreed staff education provided for debriefs	Locally agreed debrief for parents following emergency caesarean section	Women / birthing people are offered the opportunity to discuss their care before discharge from maternity services
Interdisciplinary teamwork and collaboration	Hourly buddy reviews, including ongoing risk assessment, during and following labour	Opportunities for interdisciplinary teams to share and act on learning from debriefs			

Primary Driver

Evidence based delivery of maternal care / fetal care

Secondary Drivers	Change Ideas
Safe, reliable care in labour	1: 1 care in labour and birth and immediate postnatal period
	Reliable provision of information on mobilisation, positions and analgesia in labour to women / birthing people
	Locally agreed pathway for fetal monitoring, interpretation and escalation
Effective management of malpresentation and malposition	Implementation of local malpresentation / malposition pathway
	Reliable access and provision of ECV
	ECV education/support to women / birthing people
Women / birthing people fully informed of induction of labour	Reliable implementation of locally agreed evidence based pathway and guidance for IoL
	Locally agreed escalation of care policy
	Induction of Labour education and support for women / birthing people
	Informed discussion documented, including risks and benefits of early induction of labour
Effective management of VBAC	Implementation of National VBAC guidance
	VBAC education and support for women / birthing person

Primary Driver

Leadership to promote a culture of safety at all levels

Secondary Drivers	Change Ideas
Psychological safety	Access to regular clinical supervision and/or senior support and discussion
	Create forums to allow staff to identify areas for improvement
	Visible supportive leadership
	Structured 1:1 time
	Staff aware of mechanisms available to support speaking out (including key contacts and feedback loop)
Staff wellbeing	Staff supported to celebrate success
	Access to peer support and clinical educators
	Local process to support and learn from safety walk rounds
	Promotion of National Wellbeing hub
System for learning	Local process to keep policies and guidelines up to date and communicated timeously to staff
	Locally agreed process for implementing national guidelines
	Local mechanism to support continuous learning and improvement
	Establish links with local QI support
	Information from DATIX/SAER/PMRT/complaints used to inform learning and improvement
Safe staffing	Staff education and awareness of staffing legislation and wider workforce planning principles
	Efficient and safe rostering / CoC model implemented
	Real time staffing risk assessment, escalation and mitigation
	Local maternity workforce data, including staffing levels, skill mix, experience etc. used to identify focus for improvement work
	Perinatal service staffing levels regularly reported and discussed at site level during safety huddles

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