SPSP Stillbirth Change Package

Introduction

Welcome to the stillbirth change package

The aim of the stillbirth change package is to support teams to achieve a reduction in stillbirths. A change package consists of a number of measures supported by activities that, when tested and implemented, bring about improvement. It brings together what is known about best practices and processes based on evidence from literature, research, and the experiences of others.

Why have we developed this change package?

This change package is for perinatal teams participating in stillbirth improvement work. It will support teams to use quality improvement methods to to achieve a reduction in stillbirths.

How was it developed?

This change package was co-designed with clinical and quality improvement experts from NHS boards. The clinical experts were from a range of disciplines. Expert Reference Groups (ERG) were convened in March 2023 with representation from across NHS Scotland.

Contents and how to use the package

What is included in this change package?

- Driver diagram
- Change ideas
- Guides, tools and signposts to the supporting evidence and examples of good practice
- Guidance to support measurement

Guidance on using this change package

This change package is a resource to support NHS boards to achieve a reduction in stillbirths. It is not expected for teams to work simultaneously on all aspects of the driver diagram. It is designed to assist teams in identifying areas for improvement relevant to their local context. The change ideas and measures are not exhaustive, and it is expected that teams will develop their own to support their identified areas for improvement. We would encourage teams to seek support from their local quality improvement teams in the development of additional measures if required.

Using this package

This is an interactive document; clicking on the primary/secondary driver will take you to additional information, including tools and resources relating to that driver. At the top of each page of the secondary drivers, there is an arrow  and home button  . The arrow button will take you back to the primary driver page, and the home button will take you to the main Driver Diagram page.

Project aim

Setting a project aim

All quality improvement projects should have an aim that is **S**pecific, **T**ime bound, **A**ligned to the NHS board's objectives and **N**umeric (STAN).

The national aim for stillbirths is:

Reduction in stillbirth

By [locally agreed %] by 31 March 2025

Core programme measures

Reduction in stillbirth

By [locally agreed %] by 31 March 2025

Rate of stillbirths

Driver diagram and change ideas

What is a driver diagram?

A driver diagram visually presents an organisation or team's theory of how an improvement goal will be achieved. It articulates which parts of the system need to change in which way and includes ideas of how to make this happen. It is used to help plan improvement projects and ensure team engagement.

The primary drivers are the key components of the system that need to change to deliver the aim. The secondary drivers are the processes that influence the primary drivers. Changing the processes outlined in the secondary drivers should change the primary drivers and deliver the aim.

Change ideas

Change ideas are specific practical changes the project team can make to alter the processes in the secondary drivers.
The following pages provide change ideas to support achieving a reduction in stillbirths. They are grouped by the primary driver that they influence. Project teams should select change ideas to test. A range of change ideas will be needed to ensure there are changes to all primary drivers.

This change package does not contain an exhaustive list of change ideas. Project teams can also generate their own change ideas that will help drive change in the secondary drivers. One way to generate ideas is to ask, "How might we?" For example, "How might we engage with women/birthing people and their families to improve the experience of care when in hospital?"

2023 Stillbirth Driver Diagram

Healthcare Improvement Scotland

SCOTTISH PATIENT SAFETY PROGRAMME

What we are trying to achieve…	We need to ensure…	Which requires…
Reduction in stillbirth *By [locally agreed %] by 31ST March 2025*	Person centred care* considers the Continuity of Carer approach	Women / birthing people and families listened to and included in all care decisions
		Inclusive care pathways which provide equitable and culturally appropriate access and treatment
		Awareness of altered fetal movements
		Support for women / birthing people to make healthy lifestyle choices
		Bereavement support for women / birthing people and families
	Effective fetal monitoring	Risk assessment for fetal growth restriction
		Interventions to prevent fetal growth restriction
		Surveillance of fetal growth restriction
		Effective fetal monitoring antenatally and during labour
	Safe communication*	Use of standardised tools for communication
		Management of communication
	Leadership to promote a culture of safety at all levels*	Psychological safety
		Staff wellbeing
		System for learning
		Safe staffing

Essentials of Safe Care

Primary Driver

Person centred care considers the Continuity of Carer approach

Secondary Driver	Change ideas						
Women / birthing people and families listened to and included in all care decisions	Implement CoC model of care	1: 1 care in labour and birth and immediate postnatal period	Co-produced person centred care plan including documentation of risks revisited at each antenatal contact	Person centred language is promoted and used (e.g. RCM Re:Birth) in all settings	Consider use of digital and IT systems where appropriate e.g. Near Me	Use of evidence based parent education and signposting to inform birth plans e.g. BRAINS / It's OK To Ask	Use of a universal wellbeing assessment which identify vulnerability and protected characteristics
Inclusive care pathways which provide equitable and culturally appropriate access and treatment	Co-produced person centred care plans consider ethnicity, deprivation and individual communication needs	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	
Awareness of altered fetal movements	Individualised discussion and written information regarding importance of altered fetal movement by 28 weeks	Use of Teach-back to ensure women / birthing people understand response to altered fetal movements	Local pathway for the reliable care for women reporting altered fetal movements				
Support for women / birthing people to make healthy lifestyle choices	Staff have access to education, tools and resources to inform women about risks of smoking during pregnancy	CO monitoring at booking and 36 weeks	Process in place for opt-out referral to smoking cessation services	Signpost to services to support healthy behaviour in pregnancy and beyond e.g. Ready Steady Baby / PMH Pathways / Solihull Education	Pathways include evidence based interventions to address substances harmful to health e.g. alcohol / drugs		
Bereavement support for women / birthing people and families	Implementation of National Bereavement Care Pathway	Active promotion to support services e.g. bereavement support/counselling	Opportunity for family questions that will be discussed at the SAER / PMRT	Women / birthing people are offered the opportunity to discuss their care before discharge from maternity services			

Person centred care considers the Continuity of Carer approach

Secondary driver	Change ideas
Women / birthing people and families listened to and included in all care decisions	Implement CoC model of care
	1: 1 care in labour and birth and immediate postnatal period
	Co-produced person centred care plan including documentation of risks revisited at each antenatal contact
	Person centred language is promoted and used (e.g. RCM Re:Birth) in all settings
	Consider use of digital and IT systems where appropriate e.g. Near Me
	Use of evidence based parent education and signposting to inform birth plans e.g. BRAINS / It's OK To Ask
	Use of a universal wellbeing assessment which identify vulnerability and protected characteristics

Evidence and Guidelines:

- Pace CA, Crowther S, Lau A. Midwife experiences of providing continuity of carer: A qualitative systematic review. Women Birth. 2021;35(3).
- Avagliano L, Loghi M, D'Errico A, Simeoni S, Massa V, Bulfamante GP. Risk of stillbirth in older mothers: a specific delivery plan might be considered for prevention. The journal of maternal-fetal & neonatal medicine. 2022;35(21):4137-4141.
- Fletcher R, Symonds I, StGeorge J, Warland J, Stark M. Testing the acceptability of stillbirth awareness messages in an SMS program for fathers. Health promotion journal of Australia. 2023;34(1):149-155.

Tools and Resources:

- Healthcare Improvement Scotland. What matters to you? [online] 2023; Available at: https://www.whatmatterstoyou.scot/ Accessed 13th October 2023.
- National Institute for Health and Care Excellence. Chapter 28 Structured ward rounds [online]. 2018; Available from: https://www.nice.org.uk/guidance/ng94/evidence/28.structured-ward-rounds-pdf-172397464641#:~:text=Ward%20rounds%20are%20critical%20to,steps%20in%20their%20care%20planned Accessed 13th October 2023.
- Scottish Government. Continuity of carer and local delivery of care: implementation framework [online]. 2020; Available from: https://www.gov.scot/publications/continuity-carer-local-delivery-care-implementation-framework/
- Healthcare Improvement Scotland. Anticipatory Care Planning toolkit [online]. 2021; Available from: https://ihub.scot/project-toolkits/anticipatory-care-planning-toolkit/anticipatory-care-planning-toolkit/

Person centred care considers the Continuity of Carer approach

Secondary driver	Change ideas
Inclusive care pathways which provide equitable and culturally appropriate access and treatment	Co-produced person centred care plans consider ethnicity, deprivation and individual communication needs
	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

Evidence and Guidelines:

- Matthews RJ, Draper ES, Manktelow BN, Kurinczuk JJ, Fenton AC, Dunkley-Bent J, *et al*. Understanding ethnic inequalities in stillbirth rates: a UK population-based cohort study. BMJ open. 2022;12(2):e057412.
- Catalao R, Zephyrin L, Richardson L, Coghill Y, Smylie J, Hatch S, et al. Tackling racism in maternal health. BMJ. 2023;383:e076092.
- Harpur A, Minton J, Ramsay J, et al. Trends in infant mortality and stillbirth rates in Scotland by socio-economic position, 2000–2018: a longitudinal ecological study. BMC Public Health. 2021;21:995.
- Knight M, Bunch K, Vousden N, Banerjee A, Cox P, Cross-Sudworth F, et al; MBRRACE-UK. A national cohort study and confidential enquiry to investigate ethnic disparities in maternal mortality. EClinicalMedicine. 2021 Dec 13;43:101237.
- Thomson K, Moffat M, Arisa O, et al. Socioeconomic inequalities and adverse pregnancy outcomes in the UK and Republic of Ireland: a systematic review and meta-analysis. BMJ Open 2021; 1;11(3).

Tools and Resources:

- NHS National Education for Scotland. Equality and diversity zone [online]. 2023; Available from: https://learn.nes.nhs.scot/3480

Person centred care considers the Continuity of Carer approach

Secondary driver	Change ideas
Awareness of altered fetal movements	Individualised discussion and written information regarding importance of altered fetal movement by 28 weeks
	Use of Teach-back to ensure women / birthing people understand response to altered fetal movements
	Local pathway for the reliable care for women reporting altered fetal movements

Evidence and Guidelines:

- Hayes DJL, Dumville JC, Walsh T, Higgins LE, Fisher M, Akselsson A, *et al*. Effect of encouraging awareness of reduced fetal movement and subsequent clinical management on pregnancy outcome: a systematic review and meta-analysis. American journal of obstetrics & gynecology MFM. 2023;5(3):100821.
- Andreasen LA, Tabor A, Norgaard LN, Rode L, Gerds TA, Tolsgaard MG. Detection of growth-restricted fetuses during pregnancy is associated with fewer intrauterine deaths but increased adverse childhood outcomes: an observational study. BJOG : an international journal of obstetrics and gynaecology. 2021;128(1):77-85.
- Skalecki S, Lawford H, Gardener G, Coory M, Bradford B, Warrilow K, *et al*. My Baby's Movements: An assessment of the effectiveness of the My Baby's Movements phone program in reducing late-gestation stillbirth rates. The Australian & New Zealand journal of obstetrics & gynaecology. 2023

Tools and Resources:

- Tommys. Leaflet and banner: Feeling your baby move is a sign that they are well [online]. 2020; Available from: https://www.tommys.org/pregnancy-information/health-professionals/free-pregnancy-resources/leaflet-and-banner-feeling-your-baby-move-sign-they-are-well. Accessed 13th October 2023.
- NHS Inform. Ready Steady Baby! Getting to know your baby's movements [online] 2023. Available from: https://www.nhsinform.scot/ready-steady-baby/pregnancy/your-baby-s-development/getting-to-know-your-babys-movements/. Accessed 13th October 2023.

Person centred care considers the Continuity of Carer approach

Secondary driver	Change ideas
Support for women / birthing people to make healthy lifestyle choices	Staff have access to education, tools and resources to inform women about risks of smoking during pregnancy
	CO monitoring at booking and 36 weeks
	Process in place for opt-out referral to smoking cessation services
	Signpost to services to support healthy behaviour in pregnancy and beyond e.g. Ready Steady Baby / PMH Pathways / Solihull Education
	Pathways include evidence based interventions to address substances harmful to health e.g. alcohol / drugs

Evidence and Guidelines:

- Rockliffe L, Peters S, Heazell A.E.P, Smith D.M. Factors influencing health behaviour change during pregnancy: a systematic review and meta-synthesis. Health Psychol Rev. 2021; 15(4):613-32.
- Wolfson C, Qian J, Creanga AA. Levels, Trends, and Risk Factors for Stillbirths in the United States: 2000-2017. American journal of perinatology. 2022;

Tools and Resources:

- NHS. Keeping well in pregnancy [online] 2023; Available from: https://www.nhs.uk/pregnancy/keeping-well/ Accessed 13th October 2023.
- The Solihull Approach. Online Antenatal Course [online] Available from: https://solihullapproachparenting.com/online-antenatal-course/ (enter the access code 'TARTAN' and complete a short registration form to access the courses). Accessed 13th October 2023.
- Public Health Scotland. Ready Steady Baby! Easy Read: Guidance for health professionals [online] 2022; Available from: https://www.publichealthscotland.scot/publications/ready-steady-baby-easy-read-guidance-for-health-professionals/ Accessed 13th October 2023.

Person centred care considers the Continuity of Carer approach

Secondary driver	Change ideas			
Bereavement support for women / birthing people and families	Implementation of National Bereavement Care Pathway	Active promotion to support services e.g. bereavement support/counselling	Opportunity for family questions that will be discussed at the SAER / PMRT	Women / birthing people are offered the opportunity to discuss their care before discharge from maternity services

Evidence and Guidelines:

Scottish Government. Maternity and neonatal (perinatal) adverse event review process for Scotland: Operational guidance to supplement the HIS national framework. 2021 [cited 2023 Apr 27]; Available from: https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2021/09/maternity-neonatal-perinatal-adverse-event-review-process-scotland/documents/maternity-neonatal-perinatal-adverse-event-review-process-scotland/maternity-neonatal-perinatal-adverse-event-review-process-scotland/govscot%3Adocument/maternity-neonatal-perinatal-adverse-event-review-process-scotland.pdf

Tools and Resources:

- National Bereavement Care Pathway Scotland. Stillbirth Pathway [online]. Available from: https://www.nbcpscotland.org.uk/stillbirth/ Accessed 15th September, 2023.

Primary Driver

Effective fetal monitoring

Secondary Driver	Change ideas			
Risk assessment for fetal growth restriction	Locally agreed risk assessment for growth restriction at booking and key points in antenatal care	Triage women / birthing people at risk to appropriate pathways	Boards consider use of digital aids to support risk assessment	
Interventions to prevent fetal growth restriction	Low dose aspirin following appropriate screening (PlGF UtAD) and risk assessment	Use of national standardised fundal height measurement	Use of national guideline to support plotting, interpreting and referral	Fundal height measurement from 24+0 weeks and plotted at antenatal check if not done within the last 2 weeks
Surveillance of fetal growth (SGA) restriction	Assessment of SGA and growth restricted fetus with clear local protocols for FGR	Local process to identify women / birthing people who require increased surveillance/ assessment e.g. multiple pregnancies	Explore use and benefits of fetal monitoring in the community (USS and CTG in a community (or home) setting)	
Effective fetal monitoring antenatally and during labour	Use of standardised intrapartum risk assessment tool	Local education competency programme to include fetal monitoring, fetal physiology and pathophysiology of fetal brain injury	Use of buddy system in providing holistic care	

Effective fetal monitoring

Secondary driver	Change ideas
Risk assessment for fetal growth restriction	Locally agreed risk assessment for growth restriction at booking and key points in antenatal care
	Triage women / birthing people at risk to appropriate pathways
	Boards consider use of digital aids to support risk assessment

Evidence and Guidelines:

- Vieira MC, Relph S, Muruet-Gutierrez W, Elstad M, Coker B, Moitt N, *et al*. Evaluation of the Growth Assessment Protocol (GAP) for antenatal detection of small for gestational age: The DESiGN cluster randomised trial. PLoS medicine. 2022;19(6):e1004004.
- McDonnell A, Butler M, White J, Sánchez TE, Cullen S, Cotter R, Murphy M and O'Donoghue K. National Clinical Practice Guideline: Stillbirth: Prevention, Investigation, Management and Care. 2023 [cited 2023 Apr 27]; Available from: https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/clinical-guidelines/stillbirth-prevention-investigation-management-and-care.pdf

Tools and Resources:

- NHS. Premature labour and birth [online] 2020; Available from: https://www.nhs.uk/pregnancy/labour-and-birth/signs-of-labour/premature-labour-and-birth/Accessed 13th October 2023

Effective fetal monitoring

Secondary driver	Change ideas			
Interventions to prevent fetal growth restriction	Low dose aspirin following appropriate screening (PlGF UtAD) and risk assessment	Use of national standardised fundal height measurement	Use of national guideline to support plotting, interpreting and referral	Fundal height measurement from 24+0 weeks and plotted at antenatal check if not done within the last 2 weeks

Evidence and Guidelines:

- Turner JM, Cincotta R, Chua J, Gardener G, Petersen S, Thomas J, *et al*. Decreased fetal movements-the utility of ultrasound to identify infants at risk and prevent stillbirth is poor. American journal of obstetrics & gynecology MFM. 2023;5(2):100782.
- National Institute for Health and Care Excellence. PLGF-based testing to help diagnose suspected preterm pre-eclampsia. Diagnostics guidance [DG49] [online] 2022. Available from: https://www.nice.org.uk/guidance/dg49/informationforpublic. Accessed 13th October 2023.
- Smith V, Muldoon K, Brady V, Delaney H. Assessing fetal movements in pregnancy: A qualitative evidence synthesis of women's views, perspectives and experiences. BMC Pregnancy Childbirth. 2021;21(1).

Tools and Resources:

- British Association of Perinatal Medicine. QI Publications Review – Antenatal Optimisation Edition. A BAPM QI Resource [online]. 2020. Available from: https://www.bapm.org/resources/295-qi-publications-review-antenatal-optimisation-edition. Accessed 13th October 2023.
- NHS Inform. Ready Steady Baby! Getting to know your baby's movements [online] 2023. Available from: https://www.nhsinform.scot/ready-steady-baby/pregnancy/your-baby-s-development/getting-to-know-your-babys-movements/. Accessed 13th October 2023.
- NHS. Premature labour and birth [online] 2020; Available from: https://www.nhs.uk/pregnancy/labour-and-birth/signs-of-labour/premature-labour-and-birth/Accessed 13th October 2023.

Effective fetal monitoring

Secondary driver	Change ideas
Surveillance of fetal growth (SGA) restriction	Assessment of SGA and growth restricted fetus with clear local protocols for FGR
	Local process to identify women / birthing people who require increased surveillance/ assessment e.g. multiple pregnancies
	Explore use and benefits of fetal monitoring in the community (USS and CTG in a community (or home) setting)

Evidence and Guidelines:

- Davies B, Hodnett E, Hannah M, O'Brien-Pallas L, Pringle D, Wells G; Perinatal Partnership Program of Eastern and Southeastern Ontario and the Society of Obstetricians and Gynaecologists of Canada. Fetal health surveillance: a community-wide approach versus a tailored intervention for the implementation of clinical practice guidelines. CMAJ. 2002 Sep 3;167(5):469-74.

- Butler E, Hugh O, Gardosi J. Evaluating the Growth Assessment Protocol for stillbirth prevention: progress and challenges. Journal of perinatal medicine. 2022;50(6):737-747.

Tools and Resources:

Effective fetal monitoring

Secondary driver	Change ideas
Effective fetal monitoring antenatally and during labour	Use of standardised intrapartum risk assessment tool
	Local education competency programme to include fetal monitoring, fetal physiology and pathophysiology of fetal brain injury
	Use of buddy system in providing holistic care

Evidence and Guidelines:

- National Institute for Health and Care Excellence. Antenatal care. 2021 [cited 2023 Apr 27]; Available from: https://www.nice.org.uk/guidance/ng201/resources/antenatal-care-pdf-66143709695941
- McCowan LM, Figueras F, Anderson NH. Evidence-based national guidelines for the management of suspected fetal growth restriction: comparison, consensus, and controversy. Am J Obstet Gynecol. 2018 Feb;218(2S):S855-S868

Tools and Resources:

- British Association of Perinatal Medicine. QI Publications Review – Antenatal Optimisation Edition. A BAPM QI Resource [online]. 2020. Available from: https://www.bapm.org/resources/295-qi-publications-review-antenatal-optimisation-edition. Accessed 13th October 2023.

Primary Driver

Safe communication

Secondary Driver	Change ideas			
Use of standardised tools for communication	Agreed local pathway for responding to concerns of women / birthing people when contacting triage	Use of SBAR at all transitions of care	Locally agreed process for escalation of any clinical concerns	Ward level safety brief informed by unit huddle
Management of communication	Agreed local workplan for staff trained in SAER / Perinatal review process	SCOTTIE / Prompt training for emergencies	MDT discussions at key intervals within a 24hr period	

Safe communication

Secondary driver	Change ideas

Use of standardised tools for communication	Agreed local pathway for responding to concerns of women / birthing people when contacting triage	Use of SBAR at all transitions of care	Locally agreed process for escalation of any clinical concerns	Ward level safety brief informed by unit huddle

Evidence and Guidelines:

- Müller M, Jürgens J, Redaèlli M, et al. Impact of the communication and patient hand-off tool SBAR on patient safety: a systematic review. BMJ Open. 2018;8:e022202.

Tools and Resources:

- Healthcare Improvement Scotland. Critical Situations: Management of Communication in Different Situations [online]. Available from: https://ihub.scot/improvement-programmes/scottish-patient-safety-programme-spsp/spsp-essentials-of-safe-care/safe-communications/critical-situations-management-of-communication-in-different-situations/. Accessed 15th September, 2023.

Safe communication

Secondary driver	Change ideas

Management of communication	Agreed local workplan for staff trained in SAER / Perinatal review process	SCOTTIE / Prompt training for emergencies	MDT discussions at key intervals within a 24hr period

Evidence and Guidelines:

- Wu M, Tang J, Etherington C, Walker M, Boet S. Interventions for improving teamwork in intrapartem care: a systematic review of randomised controlled trials. BMJ Qual Saf. 2020;29(1):77-85.
- Nagrecha R, Rait JS, McNairn K. Weekend handover: Improving patient safety during weekend services. Ann Med Surg (Lond). 2020 Jun 9;56:77-81.

Tools and Resources:

- Healthcare Improvement Scotland. Understanding the key components of effective morning Hospital Huddles. 2021; Available from: https://ihub.scot/media/8884/20211217-hospital-huddles-findings-and-core-elements-v10.pdf. Accessed 13th July, 2023.
- Institute for Healthcare Improvement. WIHI: Sustaining and Strengthening Safety Huddles. 2018; Available from: https://www.ihi.org/resources/Pages/AudioandVideo/WIHI-Sustaining-and-Strengthening-Safety-Huddles.aspx. Accessed 18th September 2023.
- National Institute for Health and Care Excellence. Chapter 28 Structured ward rounds [online]. 2018; Available from: https://www.nice.org.uk/guidance/ng94/evidence/28.structured-ward-rounds-pdf-172397464641#:~:text=Ward%20rounds%20are%20critical%20to,steps%20in%20their%20care%20planned

Primary Driver

Leadership to promote a culture of safety at all levels

Secondary Driver	Change ideas							
Psychological safety	Access to regular clinical supervision and/or senior support and discussion	Listening to 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	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	Implementation of local protocols and guidance that reflect national guidance	Local Process to support and learn from Safety walk rounds	SGA births reviewed by MDT for learning opportunities	Information from DATIX/SAER/PMRT/ complaints used to inform learning and improvement	Establish links with local QI support	Bereaved parents, including seldom heard groups, listened to in order to identify areas for 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			

Leadership to promote a culture of safety at all levels

Secondary driver	Change ideas
Psychological safety	Access to regular clinical supervision and/or senior support and discussion
	Listening to 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)

Evidence and Guidelines:

- Edmondson A. Psychological Safety and Learning Behavior in Work Teams. Adm Sci Q. 1999;44(2):350-383.
- NHS Providers. Psychological Safety and Why It Matters [online]. 2020; Available from: https://nhsproviders.org/news-blogs/blogs/psychological-safety-and-why-it-matters. Accessed 13th October 2023.
- Tulleners T, Campbell C, Taylor M. The experience of nurses participating in peer group supervision: A qualitative systematic review. Nurse Educ Pract. 2023;69:103606.

Tools and Resources:

- The King's Fund. The practice of collaborative leadership: Across health and care services [online]. 2023; Available from: https://www.kingsfund.org.uk/publications/practice-collaborative-leadership Accessed 13th October 2023.

Leadership to promote a culture of safety at all levels

Secondary driver	Change ideas

Staff wellbeing	Staff supported to celebrate success	Access to peer support	Local process to support and learn from safety walk rounds	Promotion of National Wellbeing hub

Evidence and Guidelines:

- Cohen C, Pignata S, Bezak E, Tie M, Childs J. Workplace interventions to improve well-being and reduce burnout for nurses, physicians and allied healthcare professionals: a systematic review. BMJ Open. 2023;13(6):e071203.
- Garcia-Catena C, Ruiz-Palomino P, Saavedra S, Gonzalez-Sanz JD. Nurses' and midwives' perceptions and strategies to cope with perinatal death situations: A systematic literature review. J Adv Nurs. 2023;79(3):910-921.
- The Kings Fund. The courage of compassion Supporting nurses and midwives to deliver high-quality care. 2020; Available from: https://www.kingsfund.org.uk/publications/courage-compassion-supporting-nurses-midwives. Accessed 15th September, 2023.

Tools and Resources:

- Healthcare Improvement Scotland. The Essentials of Safe Care: Staff Wellbeing. 2021; Available from: https://ihub.scot/improvement-programmes/scottish-patient-safety-programme-spsp/spsp-essentials-of-safe-care/leadership-and-culture/staff-wellbeing/. Accessed 13th July, 2023.
- Healthcare Improvement Scotland. What matters to you? 2023; Available from: https://www.whatmatterstoyou.scot/. Accessed 13th July, 2023.
- National Wellbeing Hub [online] Available from: https://wellbeinghub.scot/
- NHS Education for Scotland. Psychological First Aid and Debriefing - COVID 19. 2020; Available from: https://learn.nes.nhs.scot/29206. Accessed 13th July, 2023.

Leadership to promote a culture of safety at all levels

Secondary driver	Change ideas						
System for learning	Local process to keep policies and guidelines up to date and communicated timeously to staff	Implementation of local protocols and guidance that reflect national guidance	Local Process to support and learn from Safety walk rounds	SGA births reviewed by MDT for learning opportunities	Information from DATIX/SAER/PMRT/ complaints used to inform learning and improvement	Establish links with local QI support	Bereaved parents, including seldom heard groups, listened to in order to identify areas for improvement

Evidence and Guidelines:

- Scottish Government. Maternity and neonatal (perinatal) adverse event review process for Scotland: Operational guidance to supplement the HIS national framework. 2021 [cited 2023 Apr 27]; Available from: https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2021/09/maternity-neonatal-perinatal-adverse-event-review-process-scotland/documents/maternity-neonatal-perinatal-adverse-event-review-process-scotland/maternity-neonatal-perinatal-adverse-event-review-process-scotland/govscot%3Adocument/maternity-neonatal-perinatal-adverse-event-review-process-scotland.pdf
- Tsakiridis I, Giouleka S, Mamopoulos A, Athanasiadis A, Dagklis T. Investigation and management of stillbirth: a descriptive review of major guidelines. Journal of perinatal medicine. 2022;50(6):796-813.

Tools and Resources:

- Wojcieszek A and Leisher SH. Preventing stillbirth: What's the latest evidence? [online]. 2021 [cited 2023 Apr 27]; Available from: https://www.evidentlycochrane.net/preventing-stillbirth-the-latest-evidence/
- NHS Education for Scotland. Safety Culture Discussion Cards. 2023; Available from: https://learn.nes.nhs.scot/61108/human-factors-hub/human-factors-tools/safety-culture-discussion-cards/safety-culture-discussion-cards. Accessed 13th October 2023.
- Care Opinion C. Care Opinion. 2023; Available from: https://www.careopinion.org.uk/. Accessed 13th October 2023.
- Healthcare Improvement Scotland. The Essentials of Safe Care: System for Learning. 2021; Available from: https://ihub.scot/improvement-programmes/scottish-patient-safety-programme-spsp/spsp-essentials-of-safe-care/leadership-and-culture/system-for-learning/. Accessed 13th October 2023.

Leadership to promote a culture of safety at all levels

Secondary driver	Change ideas
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

Evidence and Guidelines:

- Royal College of Nursing Scotland. Staffing for Safe and Effective Care. 2022; Available from https://www.rcn.org.uk/scotland/Influencing-On-Your-Behalf/SafeStaffingScotland Accessed 15th October 2023

Tools and Resources:

- NHS Education for Scotland. Clinical Supervision Resource. 2023; Available from: https://learn.nes.nhs.scot/3580/clinical-supervision. Accessed 13th July, 2023.
- Healthcare Improvement Scotland. Workforce capacity and capability. [online]. 2021; Available from: https://ihub.scot/improvement-programmes/scottish-patient-safety-programme-spsp/spsp-essentials-of-safe-care/person-centred-care/workforce-capacity-and-capability/. Accessed 15th September, 2023
- Healthcare Improvement Scotland. Inclusion and involvement. [online]. 2021; Available from: https://ihub.scot/improvement-programmes/scottish-patient-safety-programme-spsp/spsp-essentials-of-safe-care/person-centred-care/inclusion-and-involvement/. Accessed 15th September, 2023
- Healthcare Improvement Scotland. Staffing level (workload) tools and methodology. [online]. Available from: https://www.healthcareimprovementscotland.org/our_work/patient_safety/healthcare_staffing_programme/staffing_workload_tools.aspx. Accessed 15th September, 2023
- NHS Education for Scotland. Health and Care Staffing in Scotland. [online]. 2019; Available from: https://learn.nes.nhs.scot/61827. Accessed 15th September, 2023

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