SPSP Maternal Deterioration Change Package

Introduction

Welcome to the maternal deterioration change package

The aim of the maternal deterioration change package is to support teams to reduce harm from deterioration in acute hospitals by improving the recognition, response and review of the deteriorating woman / birthing person. 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 maternal deterioration improvement work. It will support teams to use quality improvement methods to reduce harm from deterioration in acute hospitals by improving the recognition, response and review of the deteriorating woman / birthing person.

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 reduce harm from deterioration in acute hospitals by improving the recognition, response and review of the deteriorating woman / birthing person. 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 Maternal Deterioration is:

To reduce harm from deterioration in acute hospitals by improving the recognition, response and review of the deteriorating woman / birthing person*

By [locally agreed aim]
By 31st March 2025

Measurements include existing Excellence in Care data

Core programme measures

To reduce harm from deterioration in acute hospitals by improving the recognition, response and review of the deteriorating woman / birthing person *

By [locally agreed %] by 31st March 2025

Percentage of Maternity Early Warning Score (MEWS) charts completed and frequency met

Percentage compliance with MEWS chart escalation pathway

PPH rate – over 1.5 litre

Balancing measure – number of maternity admissions to ITU

Measurements include existing Excellence in Care data

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 improvement to reduce harm from deterioration in acute hospitals by improving the recognition, response and review of the deteriorating woman / birthing person. 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 Maternal Deterioration Driver Diagram

Healthcare Improvement Scotland | Scottish Patient Safety Programme

What we are trying to achieve…	We need to ensure…	Which requires…
To reduce harm from deterioration in acute hospitals by improving the recognition, response and review of the deteriorating woman / birthing person ** *By [locally agreed %] by 31st March 2023*	Person centred care* considers the Continuity of Carer approach	Women / birthing people and families are listened to and included in all care decisions Person centred care planning Inclusive care pathways which provide equitable and culturally appropriate access and treatment
	Recognition of acute deterioration	Observation using MEWS (Scotland) Action on staff concern Action on women / birthing people / family concern
	Standardised structured response and review	Timely review by appropriate healthcare practitioner Assessment for causes of acute deterioration Escalation Regular review and assessment
	Safe communication*	Effective communication in different situations Use of standardised tools for communication Interdisciplinary teamwork and collaboration
	Leadership to promote a culture of safety at all levels*	Psychological safety Staff wellbeing System for learning Safe staffing

Essentials of Safe Care

****Measurements include existing Excellence in Care data***

Primary Driver

Person centred care considers the Continuity of Carer approach

Secondary Driver	Change ideas						
Women / birthing people and families are listened to and included in all care decisions	Local process to escalate women / birthing people concerns – asking what matters to you	Person centred language is promoted and used (e.g. RCM Re:Birth) in all settings	Use of a universal wellbeing assessment which identify vulnerability and protected characteristics				
Person centred care planning	Implement CoC model of care	1: 1 care in labour and birth and immediate postnatal period	Women / birthing people identified as high risk have a co-produced person centred care plan with a focus on deterioration	Women / birthing people identified as at risk of PPH have a person centred care plan which includes a PPH risk assessment			
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	

Person centred care considers the Continuity of Carer approach

Secondary drivers	Change ideas		
Women / birthing people and families are listened to and included in all care decisions	Local process to escalate women / birthing people concerns – asking what matters to you	Person centred language is promoted and used (e.g. RCM Re:Birth) in all settings	Use of a universal wellbeing assessment which identify vulnerability and protected characteristics

Evidence and Guidelines:

- McCann E, Brown M, Hollins-Martin C, Murray K, McCormick F. The views and experiences of LGBTQ+ people regarding midwifery care: A systematic review of the international evidence. Midwifery. 2021;103:103102.

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.

Person centred care considers the Continuity of Carer approach

Secondary drivers	Change ideas			
Person centred care planning	Implement CoC model of care	1: 1 care in labour and birth and immediate postnatal period	Women / birthing people identified as high risk have a co-produced person centred care plan with a focus on deterioration	Women / birthing people identified as at risk of PPH have a person centred care plan which includes a PPH risk assessment

Evidence and Guidelines:

- National Institute for Health and Care Excellence. Intrapartum care for healthy women and babies. 2014 [cited 2023 May 01]; Available from: https://www.nice.org.uk/guidance/cg190/resources/intrapartum-care-for-healthy-women-and-babies-pdf-35109866447557
- National Institute for Health and Care Excellence. Postnatal care. 2021 [cited 2023 May 01]; Available from: https://www.nice.org.uk/guidance/ng194/resources/postnatal-care-pdf-66142082148037
- Pace CA, Crowther S, Lau A. Midwife experiences of providing continuity of carer: A qualitative systematic review. Women Birth. 2021;35(3).
- Mamun A, Biswas T, Scott J, Sly PD, McIntyre HD, Thorpe K, et al. Adverse childhood experiences, the risk of pregnancy complications and adverse pregnancy outcomes: a systematic review and meta-analysis. BMJ Open. 2023;13(8).

Tools and Resources:

- 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/
- NHS National Education for Scotland. National trauma training programme [online]. 2023; Available from: https://learn.nes.nhs.scot/37898

Person centred care considers the Continuity of Carer approach

Secondary drivers	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:

- Brown H, Jesurasa A, Bambra C, Rankin J, McNaughton A and Heslehurst N. Assessing the relationship between adverse pregnancy outcomes and area-level deprivation in Wales 2014-2019: a national population-based cross-sectional study. BMJ open. 2021;11(11):e052330.
- Catalao R, Zephyrin L, Richardson L, Coghill Y, Smylie J, Hatch S, et al. Tackling racism in maternal health. BMJ. 2023;383:e076092.
- McCann E, Brown M, Hollins-Martin C, Murray K, McCormick F. The views and experiences of LGBTQ+ people regarding midwifery care: A systematic review of the international evidence. Midwifery. 2021; 103; e103102. doi: https://doi.org/10.1016/j.midw.2021.103102
- Khan Z, Vowles Z, Fernandez Turienzo C, et al. Targeted health and social care interventions for women and infants who are disproportionately impacted by health inequalities in high-income countries: a systematic review. Int J Equity Health. 2023;22(1):131.
- Royal College of Midwives. Position Statement: midwives to address the needs of women experiencing severe and multiple disadvantage [online]. 2021; Available from: https://www.rcm.org.uk/media/5449/rcm-position-statement-women-experiencing-severe-and-multiple-disadvantage-2021_2.pdf
- 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

Primary Driver

Recognition of acute deterioration

Secondary Driver	Change ideas		
Observations using Maternity Early Warning Score (MEWS)	Use of MEWS for all pregnant or post partum women / birthing people	Access to staff education, tools and resources to support use of MEWS	Locally agreed process to notify maternity services when pregnant or post partum woman / birthing person admitted to hospital
Action on staff concern	Locally agreed process to escalate clinical concern out with MEWS trigger		
Action on woman / birthing person / family concern	Locally agreed process for women / birthing people / families to escalate concerns	Women / birthing people / families informed of process to escalate concerns	

Recognition of acute deterioration

Secondary drivers	Change ideas		
Observations using Maternity Early Warning Score (MEWS)	Use of MEWS for all pregnant or post partum women / birthing people	Access to staff education, tools and resources to support use of MEWS	Locally agreed process to notify maternity services when pregnant or post partum woman / birthing person admitted to hospital

Evidence and Guidelines:

- National Institute for Health and Care Excellence. Acutely ill adults in hospital: recognising and responding to deterioration. 2007 [cited 2023 May 01]; Available from: https://www.nice.org.uk/guidance/cg50/resources/acutely-ill-adults-in-hospital-recognising-and-responding-to-deterioration-pdf-975500772037
- Austin DM, Sadler L, McLintock C, et al. Early detection of severe maternal morbidity: A retrospective assessment of the role of an Early Warning Score System. Australian and New Zealand Journal of Obstetrics and Gynaecology. 2014;54(2):152-155.
- Isaacs RA, Wee MYK, Bick DE, Beake S, Sheppard ZA, Thomas S, et al. A national survey of obstetric early warning systems in the United Kingdom: five years on. Anaesthesia. 2014;69(7):687-92.
- Isaacs R, Smith G, Gale-Andrews L, Wee M, van Teijlingen E, Bick D, *et al*. Design errors in vital sign charts used in consultant-led maternity units in the United Kingdom. International journal of obstetric anesthesia. 2019;39(60-67.

Tools and Resources:

- The Improvement Hub H. The Scottish Maternity Early Warning System (MEWS) 2018 [2022 Apr 11]. Available from: National MEWS | Scottish Patient Safety Programme (SPSP) | ihub - Scottish Maternity Early Warning System (MEWS)
- Rutter H. Early Recognition and Management of Deterioration of Women and Babies. no date [cited 2023 May 01]; Available from: https://emahsn.org.uk/images/Early_Recognition_and_Management_of_Deterioration_of_Women_and_Babies_-_Hannah_Rutter_PDF.pdf

Recognition of acute deterioration

Secondary drivers	Change ideas
Action on staff concern	Locally agreed process to escalate clinical concern out with MEWS trigger

Evidence and Guidelines:

- Mackintosh N, Sandall J. The social practice of rescue: the safety implications of acute illness trajectories and patient categorisation in medical and maternity settings. Sociology of Health & Illness. 2016;38(2):252-269.

Tools and Resources:

Recognition of acute deterioration

Secondary drivers	Change ideas	
Action on woman / birthing person / family concern	Locally agreed process for women / birthing people / families to escalate concerns	Women / birthing people / families informed of process to escalate concerns

Evidence and Guidelines:

- Mackintosh NJ, Davis RE, Easter A, Rayment-Jones H, Sevdalis N, Wilson S, *et al*. Interventions to increase patient and family involvement in escalation of care for acute life-threatening illness in community health and hospital settings The Cochrane database of systematic reviews. 2020;12(CD012829.

Tools and Resources:

Primary Driver

Standardised and structured response and review

Secondary Driver	Change ideas		
Timely review by appropriate healthcare practitioner	Process for timely clinical review from identification of deterioration	Use of standardised structured ward rounds	
Assessment for causes of acute deterioration	Implementation of PPH 4 stage approach	Implementation of Sepsis 6	Use of structured A-F assessment
Escalation	Locally agreed process for escalation	Locally agreed process for timely transfer to appropriate care setting	Agreed common language used for escalation
Regular review and assessment	Local escalation process incudes follow up patient review	Locally agreed roles and responsibilities in relation to review and reassessment	

Standardised and structured response and review

Secondary drivers	Change ideas	
Timely review by appropriate healthcare practitioner	Process for timely clinical review from identification of deterioration	Use of standardised structured ward rounds

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.
- 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

Tools and Resources:

- 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

Standardised and structured response and review

Secondary drivers	Change ideas		
Assessment for causes of acute deterioration	Implementation of PPH 4 stage approach	Implementation of Sepsis 6	Use of structured A-F assessment

Evidence and Guidelines:

- National Institute for Health and Care Excellence. Sepsis: recognition, diagnosis and early management. 2016 [cited 2023 May 01]; Available from: https://www.nice.org.uk/guidance/ng51/resources/sepsis-recognition-diagnosis-and-early-management-pdf-1837508256709
- Royal College of Obstetricians & Gynaecologists. Bacterial Sepsis following Pregnancy. 2012 [cited 2023 May 01]; Available from: https://www.rcog.org.uk/media/bfnkzznd/gtg_64b.pdf
- Royal College of Obstetricians & Gynaecologists. Bacterial Sepsis in Pregnancy. 2012 [cited 2023 May 01]; Available from: https://www.rcog.org.uk/media/ea1p1r4h/gtg_64a.pdf
- Mavrides E AS, Chandraharan E, Collins P, Green L, Hunt BJ, Riris S, *et al*. Prevention and Management of Postpartum Haemorrhage. BJOG: An International Journal of Obstetrics & Gynaecology. 2017;124(5):e106-e149.

Tools and Resources:

- Healthcare Improvement Scotland. Postpartum Haemorrhage 4-Stage Approach: Practical Guide. [online]. 2018; Available from: https://ihub.scot/media/5690/pph-4-stage-practical-guide_final.pdf Accessed 15th September, 2023

Standardised and structured response and review

Secondary drivers	Change ideas		
Escalation	Locally agreed process for escalation	Locally agreed process for timely transfer to appropriate care setting	Agreed common language used for escalation

Evidence and Guidelines:

- Sultan P, Arulkumaran N, Rhodes A. Provision of critical care services for the obstetric population. Best Practice and Research Clinical Obstetrics and Gynaecology. 2013;27(6):803-809.
- Farr A, Lenz-Gebhart A, Einig S, Ortner C, Holzer I, Elhenicky M, *et al*. Outcomes and trends of peripartum maternal admission to the intensive care unit. Wiener klinische Wochenschrift. 2017;129(17-18):605-611.

Tools and Resources:

- The Improvement Hub H. The Scottish Maternity Early Warning System (MEWS) 2018 [2022 Apr 11]. Available from: National MEWS | Scottish Patient Safety Programme (SPSP) | ihub - Scottish Maternity Early Warning System (MEWS)
- Rutter H. Early Recognition and Management of Deterioration of Women and Babies. no date [cited 2023 May 01]; Available from: https://emahsn.org.uk/images/Early_Recognition_and_Management_of_Deterioration_of_Women_and_Babies_-_Hannah_Rutter_PDF.pdf

Standardised and structured response and review

Secondary drivers	Change ideas	
Regular review and assessment	Local escalation process incudes follow up patient review	Locally agreed roles and responsibilities in relation to review and reassessment

Evidence and Guidelines:

- Merriel A, van der Nelson H, Merriel S, Bennett J, Donald F, Draycott T, *et al*. Identifying Deteriorating Patients Through Multidisciplinary Team Training. American journal of medical quality : the official journal of the American College of Medical Quality. 2016;31(6):589-595.

Tools and Resources:

- NHS Education for Scotland. Leading for the Future: Communication Skills Resources [online]. 2018; Available from: https://learn.nes.nhs.scot/11233/leadership-and-management-programmes/leading-for-the-future/communication-skills-resources. Accessed 15th September, 2023.

Primary Driver

Safe communication

Secondary Driver	Change ideas			
Effective communication in different situations	Daily MDT review for critically ill person embedded in practice	Identifying people at risk of maternal deterioration at site safety huddles	Ward level / unit safety brief informed by site safety huddle	
Use of standardised tools for communication	Use of SBAR tool for escalation / all transitions of care			
Interdisciplinary teamwork and collaboration	Develop local process for MDT hot and cold debriefs	Use of MDT hot and cold debriefs	Sharing of learning from reviews / debriefs	Agreed local workplan for staff trained in SAER

Safe communication

Secondary drivers	Change ideas		
Effective communication in different situations	Daily MDT review for critically ill person embedded in practice	Identifying people at risk of maternal deterioration at site safety huddles	Ward level / unit safety brief informed by site safety huddle

Evidence and Guidelines:

- National Institute for Health and Care Excellence. Intrapartum care for women with existing medical conditions or obstetric complications and their babies. 2019 [cited 2023 May 01]; Available from: https://www.nice.org.uk/guidance/ng121/resources/intrapartum-care-for-women-with-existing-medical-conditions-or-obstetric-complications-and-their-babies-pdf-66141653845957
- Blackburn G, Rasmussen B, Wynter K, Holton S. Proactive rounding: Perspectives and experiences of nurses and midwives working in a large metropolitan hospital. Australian critical care : official journal of the Confederation of Australian Critical Care Nurses. 2022;35(6):684-687.

Tools and Resources:

- NHS Education for Scotland. Leading for the Future: Communication Skills Resources [online]. 2018; Available from: https://learn.nes.nhs.scot/11233/leadership-and-management-programmes/leading-for-the-future/communication-skills-resources. Accessed 15th September, 2023.
- 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.
- Institute for Healthcare Improvement (IHI). Patient Safety Essentials Toolkit [online]. Available from: https://www.ihi.org/resources/Pages/Tools/Patient-Safety-Essentials-Toolkit.aspx. Accessed 15th September, 2023.

Safe communication

Secondary drivers	Change ideas
Use of standardised tools for communication	Use of SBAR tool for escalation / all transitions of care

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 drivers	Change ideas			
Interdisciplinary teamwork and collaboration	Develop local process for MDT hot and cold debriefs	Use of MDT hot and cold debriefs	Sharing of learning from reviews / debriefs	Agreed local workplan for staff trained in SAER

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

Healthcare Improvement Scotland

Every Person Every Time – Scottish Patient Safety Programme

Secondary Driver	Change ideas							
Psychological safety	Access to clinical supervision	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	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	MDT training for emergencies E.G. SCOTTIE/ Prompt/REACTS	Standardised approach to MDT review and learning	Process for local review of maternity related Scottish Intensive Care Society Audit Group (SICSAG) data	Locally agreed midwifery education should include acute deterioration / caring for critically ill women / birthing people	Information from DATIX/SAER/PMRT /complaints used to inform learning and improvement	Establish links with local QI support	
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 drivers	Change ideas				
Psychological safety	Access to clinical supervision	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)

Evidence and Guidelines:

- Edmondson A. Psychological Safety and Learning Behavior in Work Teams. Administrative Science Quarterly. 1999 Jun;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 15th September, 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

Leadership to promote a culture of safety at all levels

Secondary drivers	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 drivers	Change ideas						
System for learning	Local process to keep policies and guidelines up to date and communicated timeously to staff	MDT training for emergencies E.G. SCOTTIE/ Prompt/REACTS	Standardised approach to MDT review and learning	Process for local review of maternity related Scottish Intensive Care Society Audit Group (SICSAG) data	Locally agreed midwifery education should include acute deterioration / caring for critically ill women / birthing people	Information from DATIX/SAER/PMRT /complaints used to inform learning and improvement	Establish links with local QI support

Evidence and Guidelines:

- Hastings-Tolsma M, Nolte AGW. Reconceptualising failure to rescue in midwifery: a concept analysis. Midwifery. 2014;30(6):585-94.

Tools and Resources:

- Wood J. Maternity and Neonatal Safety Improvement Programme (MatNeoSIP). 2021 [cited 2023 May 01]; Available from: https://www.ahsn-nenc.org.uk/wp-content/uploads/2021/03/MatNeo-Breakout.pdf
- Public Health Scotland. Maternity and Births: Available from: Maternity and births - Our areas of work - Public Health Scotland
- National Maternity and Perinatal Audit. Available from: Homepage (maternityaudit.org.uk)
- 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 drivers	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
- British Association of Perinatal Medicine. Calculating Unit Cot numbers and Nurse Staffing Establishment and Determining Cot Capacity. A BAPM Framework for Practice – Supplementary Guidance [online]. 2019; Available from: https://www.bapm.org/resources/157-calculating-unit-cot-numbers-and-nurse-staffing-establishment-and-determining-cot-capacity

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

Contact details

his.spsppp@nhs.scot

@mcqicspsp @online_his

#spsp247 #PerinatalCare

Edinburgh Office

Gyle Square

1 South Gyle Crescent

Edinburgh

EH12 9EB

0131 623 4300

Glasgow Office

Delta House

50 West Nile Street

Glasgow

G1 2NP

0141 225 6999