Health Innovation West of England

West of England Patient Safety Collaborative

Perinatal Culture and Leadership Programme

2024-2026 Programme Summary Report

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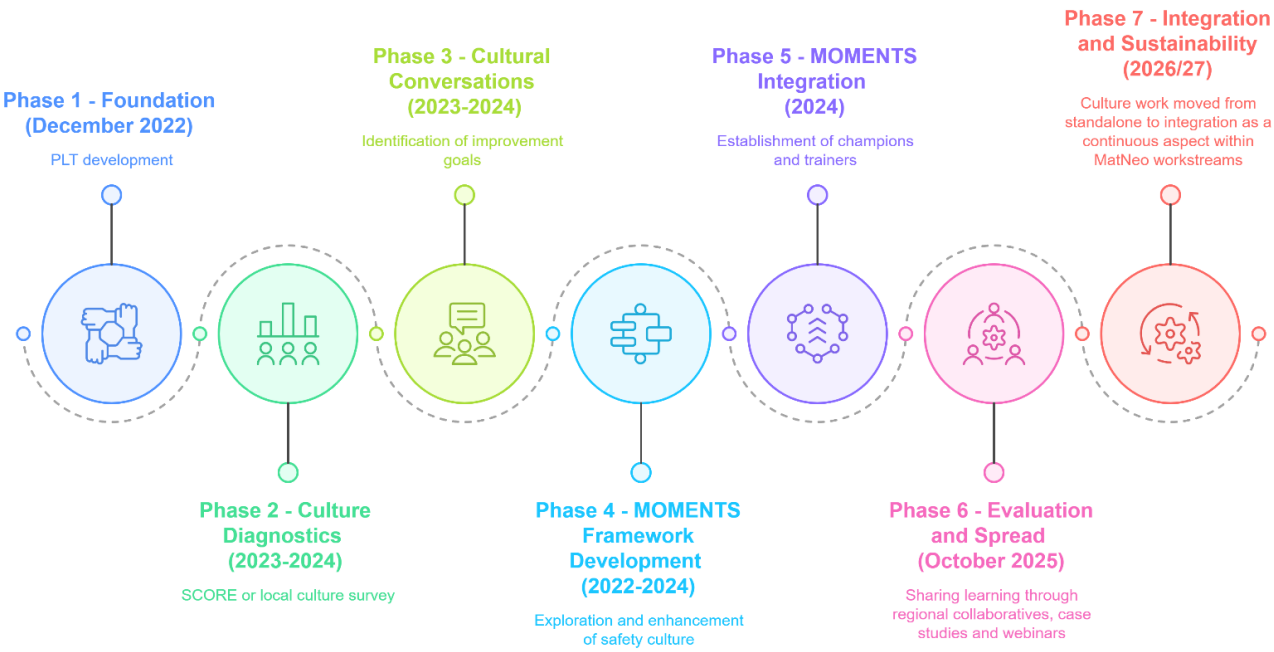
Executive Summary

The Perinatal Culture and Leadership Programme (PCLP) was a national NHS England (NHSE) initiative designed to strengthen perinatal leadership and foster a positive, compassionate culture of safety and continuous improvement across maternity and neonatal services. The programme continues to run as a thread throughout on-going Maternity and Neonatal Safety Improvement Programmes, which is explored further in the report.

Co-developed with national stakeholders, regional teams, service users and perinatal leaders, the programme was a direct response to learning from the Ockenden (2022) and Kirkup (2022) reviews and supports national ambitions to improve outcomes for women, babies and families through more collaborative, psychologically safe and effective team working.

The programme focused on the senior perinatal leadership team (PLT) or 'Quad' and was delivered in three interconnected phases:

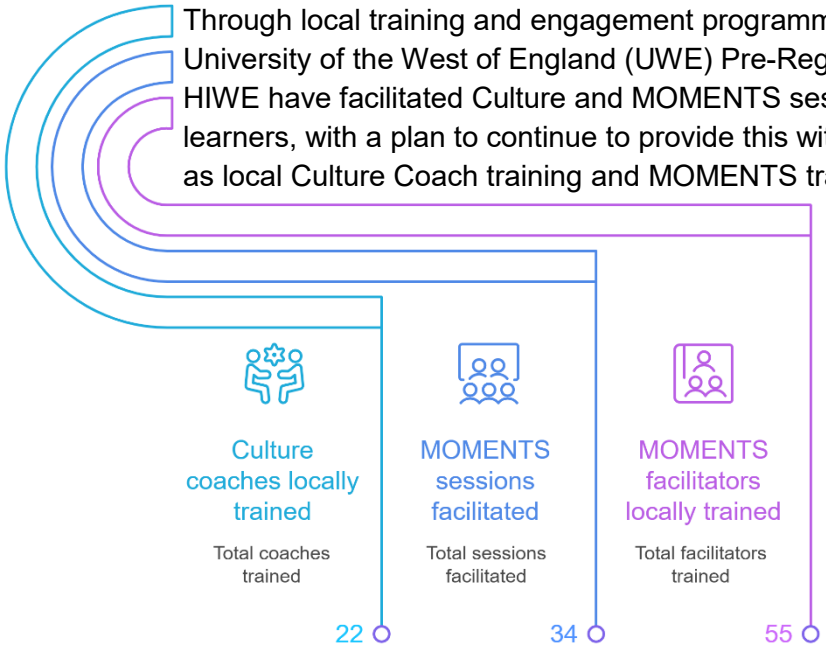
- Phase 1 provided structured leadership development for PLTs over six to seven months, combining face-to-face modules, action learning sets and leadership feedback to strengthen trust, shared purpose and the ability to lead culture change.
- Phase 2 offered the optional SCORE safety culture survey, enabling services to gain insight into how it feels to work within their teams, identify strengths and opportunities, and understand the relational factors that influence safety and improvement.
- Phase 3 supports the socialisation of survey findings and planning for improvement through facilitated cultural conversations and coaching. Independent culture coaches worked with PLTs and their locally identified change teams to help teams collectively interpret the results, build shared understanding, and agree a small number of meaningful, locally relevant improvement priorities.



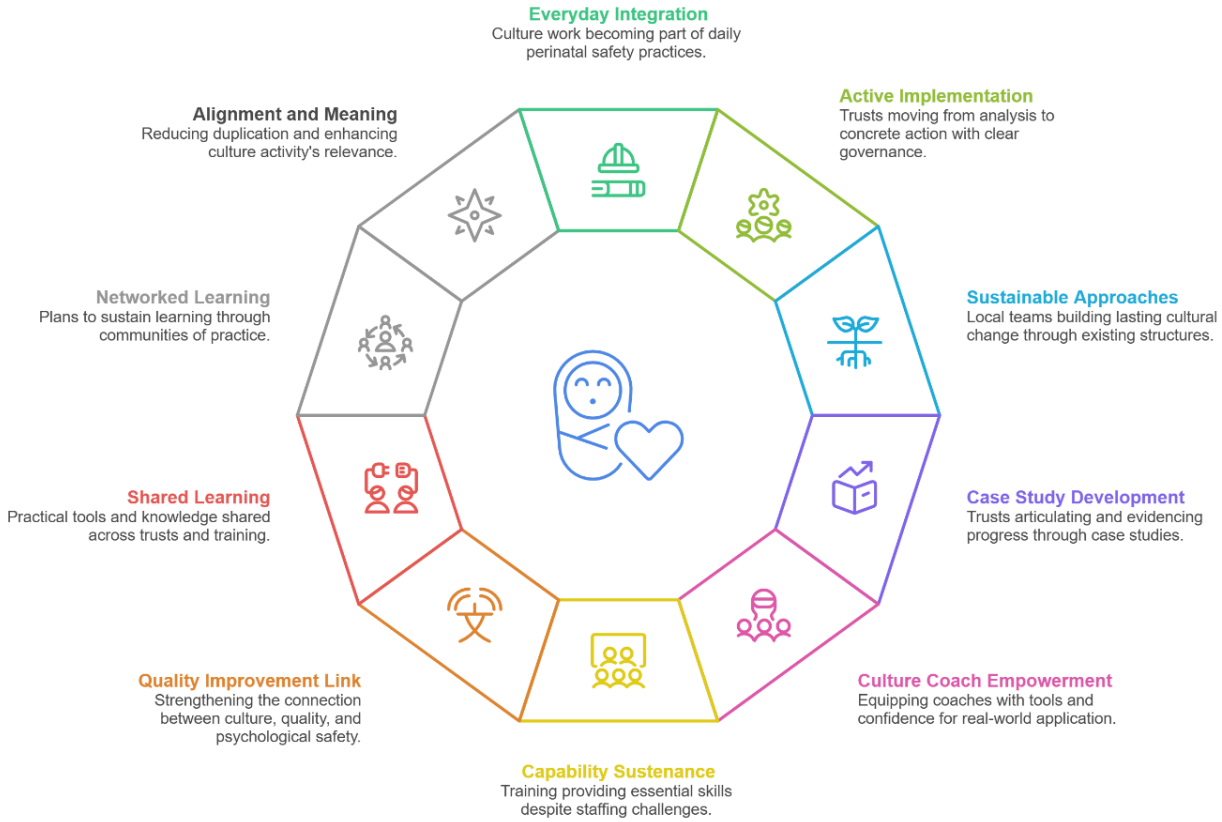
Health Innovation West of England (HIWE) commenced support of the PCLP in April 2024 as part of the Patient Safety Commission to provide on-going support to our five local PLTs to implement and further develop their improvement plans with a quality improvement (QI) lens, including offering and delivering QI coaching.

Using QI coaching skills, HIWE continued building on improvement planning with a focus on developing relationships and collaboration across the perinatal team, and motivating improvement based on the shared vision and purpose established in phases one to three. We supported the adoption and spread of safety culture interventions and resources, as well as newly emerging evidence-based tools – i.e., the MOMENTS framework.

Through local training and engagement programmes, including partnership with the University of the West of England (UWE) Pre-Registration Midwifery programme HIWE have facilitated Culture and MOMENTS sessions to three Year-2 cohorts of learners, with a plan to continue to provide this within the current curriculum, as well as local Culture Coach training and MOMENTS training and facilitation.

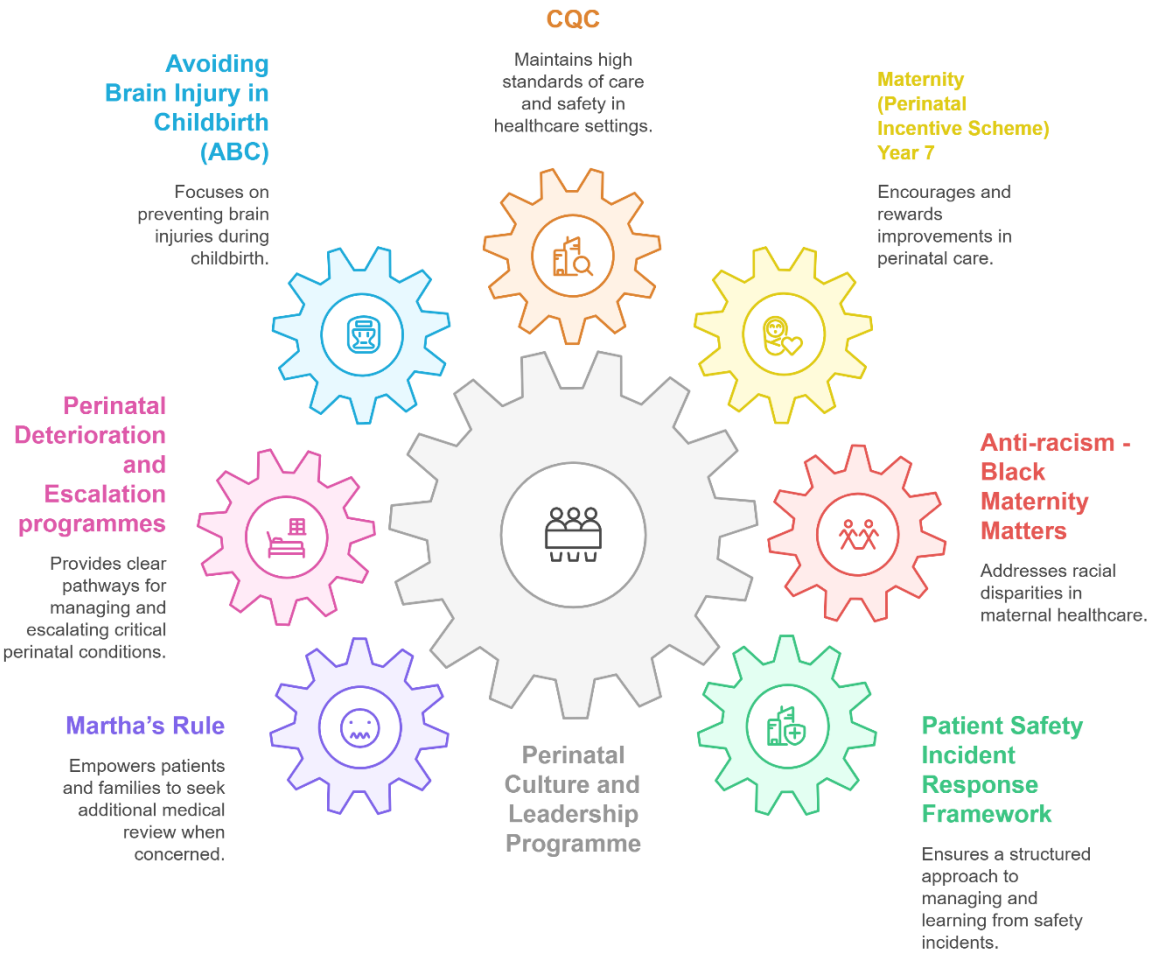


Within both the programme years, HIWE achieved all programme deliverables, with engagement and participation from all five sites, whilst utilising the opportunity to reinforce links to wider perinatal reporting and assurance programmes to support sustainability and reduce addition of burden through:



Alongside the above training and facilitation, HIWE also supported the PLTs and local Trusts through:

- ✓ In-person events to facilitate peer learning and networking.
- ✓ Access to both executive and quality improvement coaching.
- ✓ Developing Leaders training (as PLTs were in flux and had not had the opportunity to develop and bond as in Phase 1 of the programme due to changes across the system).
- ✓ Support to integrate the MOMENTS conversation tool into Practical Obstetric Multi-Professional Training (PROMPT) and alignment with local Patient Safety Incident Response Framework (PSIRF) implementation.
- ✓ Practical alignment of the programme with Maternity (Perinatal) Incentive Scheme (MIS) Year 7.
- ✓ Alignment of the programme activity with Black Maternity Matters (anti-racism programme), Martha's Rule, perinatal escalation and deterioration, and more recently, the Avoiding Brain injury in Childbirth (ABC) workstreams.
- ✓ Collaborative events with the South West and Wessex Health Innovation Networks to support wider, regional learning and networking.
- ✓ Presentation of approach and integration of MOMENTS across patient safety programmes at a national MOMENTS webinar, hosted by the University of Leicester SAPPHIRE research team that developed the tool.
- ✓ Facilitation of a MOMENTS session at a South West Regional Professional Midwifery and Nursing Advocates quality improvement virtual away day, in partnership with the NHS England South West Regional Maternity and Neonatal Team.



Case studies and further details are explored in the full report. *Links within the following report may take you to resources which have been developed and shared via the NHS Futures platform, if you are not a member of the Maternity and Neonatal Hub, you may need to join to access these links.*

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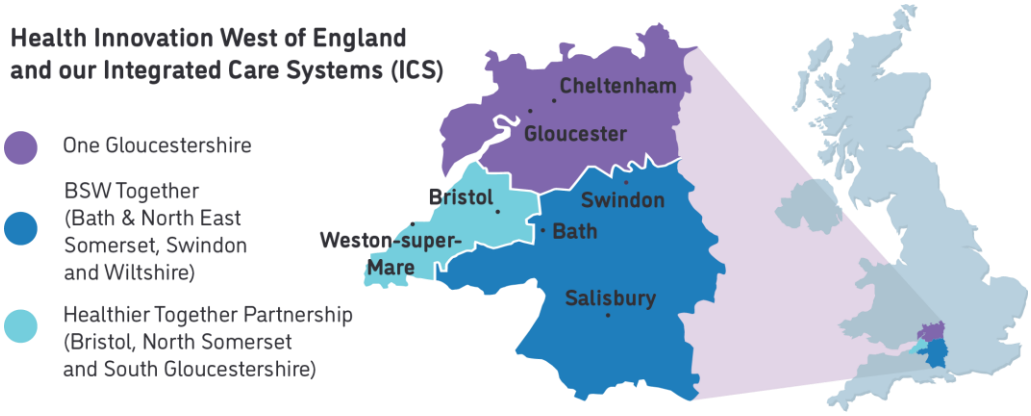
Health Innovation West of England

We are one of 15 health innovation networks across England. Formerly called 'academic health science networks', we were first licensed by NHS England in 2013 to operate as the key innovation arm of the NHS.



With core funding from NHS England and the government's Office for Life Sciences, our collective aim is to spread health innovation at pace and scale – improving health, transforming lives and generating economic growth.

Our regional focus:



We enable collaborating and connecting by bringing together all the key players who play a role in innovating health and care, including:

- NHS providers and commissioners
- Social care providers
- Patients, carers and the wider public
- Industry
- Universities and research bodies
- Local authorities
- The voluntary, community and social enterprise sector

Central to our work in healthcare service and system transformation is our award-winning support for improving patient safety.

Our patient safety work programme is informed by the NHS Patient Safety Strategy, and the National Patient Safety Improvement Programme (known as NatPatSIP). Our goal is to ensure that patients in the West of England can be confident that care is safe for patients based on a culture of openness, collaboration, continuous learning and quality improvement.

Patient Safety Collaborative

Our patient safety work is delivered by the West of England Patient Safety Collaborative (PSC). We host and coordinate the PSC. Our PSC is made up of all the NHS providers and commissioners across the region, including hospitals, mental health and community organisations, the ambulance service, primary care and clinical commissioning groups. It brings together local patients and healthcare staff, all driven by a shared vision to bring about system-wide improvements to ensure the safety and wellbeing of people in the care of our health services.

Programme Aim and Ambition

The Perinatal Culture and Leadership Programme (PCLP) was designed to strengthen perinatal leadership as a critical driver of safety, quality and improvement within maternity and neonatal services. It directly responds to the 2022 Ockenden and Kirkup reports, which identified recurring failures in leadership, culture, teamworking and organisational learning as central contributors to harm. The programme recognises that improving outcomes for women and babies requires more than technical solutions. It requires compassionate, inclusive leadership and cultures that enable learning, escalation, curiosity and collaboration.

At its core, the programme aimed to improve the quality of care by enabling perinatal leaders to better understand and actively influence the relationship between leadership, safety improvement and safety culture. It supported perinatal leadership teams to create and sustain the conditions for a positive culture of safety and continuous improvement, characterised by psychological safety, openness and shared accountability. This focus addresses key themes from national reviews, including siloed working, suppression of staff voice, poor response to concerns and a lack of relational leadership across professional boundaries.

The PCLP programme is closely aligned with, and actively supports, the implementation of the PSIRF from April 2024. PSIRF places culture, leadership and learning at the centre of patient safety, shifting the focus away from process-driven investigation towards compassionate engagement, system learning and improvement. By developing leadership capability, psychological safety and collective sense-making, the programme creates the cultural conditions required for PSIRF to be implemented effectively. In turn, PSIRF reinforces the programme's aims by providing a consistent national framework that values curiosity, listening, learning and proportionate response, all of which depend on strong perinatal leadership and healthy team culture.

Through this alignment, the programme supports NHSE's ambition to reduce neonatal mortality by 50 percent by strengthening the foundations of safe care, across the programmes of work and in line with the Saving Babies Lives Care Bundle.

Leaders who understand and prioritise culture are better able to recognise risk early, support staff to speak up, learn from incidents and near misses, and apply systemic improvement rather than individual blame.

The expected outcomes of the programme included measurable improvements in safety and culture at Trust and system level, aligned with local and system priorities. It aimed to improve staff experience and satisfaction in maternity and neonatal services by creating working environments where people feel valued, supported and able to contribute to improvement. Ultimately, by embedding strong, compassionate leadership the programme sought to deliver safer, more reliable perinatal care and improved outcomes for women and babies, ensuring that the lessons from Ockenden and Kirkup lead to sustained cultural change.

Project Approach and Engagement Activities

All Trusts providing perinatal services were supported by NHSE Maternity Transformation Team during 2023/2024 to continue to sustainably develop leadership capacity, capability and improvement relating to safety culture in their units and as part of their local systems, building on the progress made during Phase 1-3 of the PCLP.

The PCLP was designed to support perinatal leadership teams to create and craft the conditions for a positive culture of safety and continuous improvement, have a positive impact on the experiences of women, families and babies and enable a more collaborative, supportive workplace. It also aimed to enable psychologically safe working environments and develop compassionate leadership to make work a better place to be.

The PCLP programme had three initial phases:

Phase 1: Team 'Quad' or PLT development– this stage focused on the perinatal senior leadership team, responsible for supporting, role modelling and leading the cultural environment, usually consisting of Head or Director of Midwifery, Clinical Lead / Director for Obstetrics, Neonatal Clinical Lead / Director or Head of Neonatal Nursing and an operational representative. This phase has enabled Quads to connect as a team with a renewed common purpose and give them the headspace needed to problem solve and plan for the future.

Phase 2: Optional SCORE culture survey to gain insight into teams' safety culture 'how it feels to work here', to help the team identify strengths and opportunities and to understand the role that relationships have in supporting improvement. (SCORE = Safety Culture, Operational Risk, Reliability/burnout and Engagement)

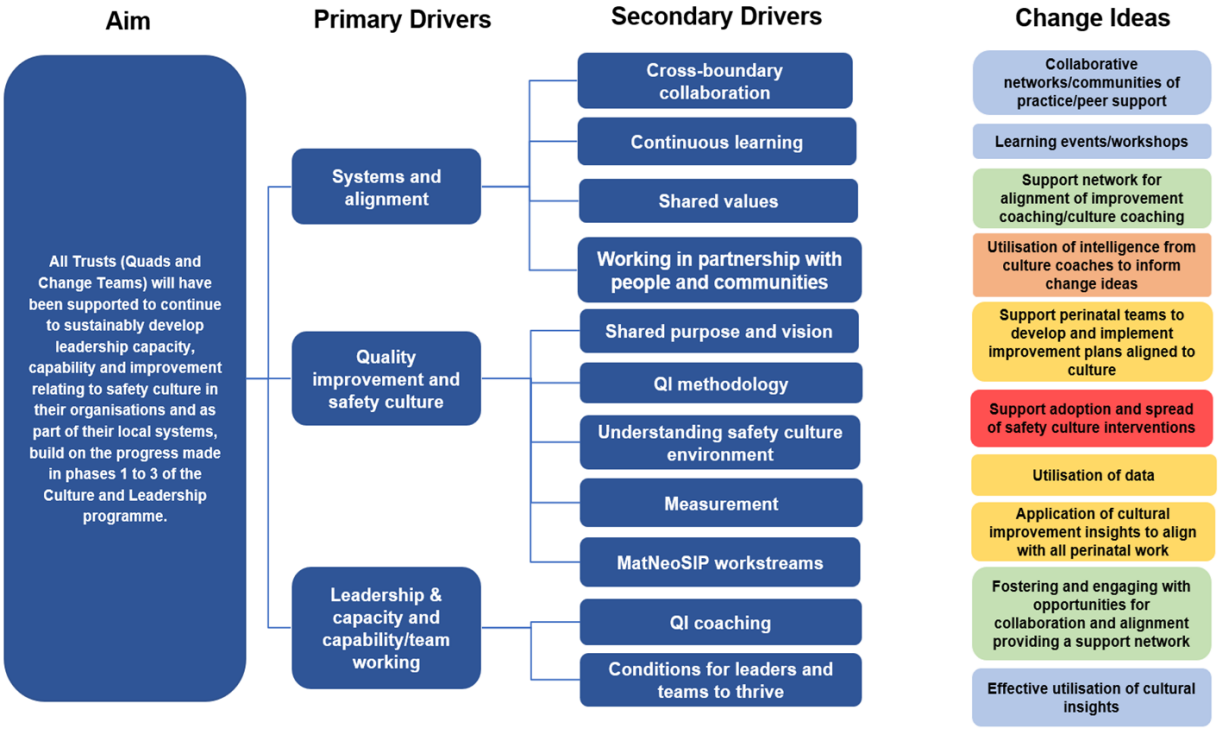
Of note, only two organisations from England chose not to participate in the SCORE survey, utilising internal insights and surveys recently completed instead – one of which was in the West of England locality.

Phase 3: Cultural conversations and planning for improvement – PLTs supported by an independent culture coach to have conversations about the culture survey findings with their teams. PLTs and their change team will then be supported to co-develop an improvement plan based around a small number of identified key themes and linking with other work they are doing.

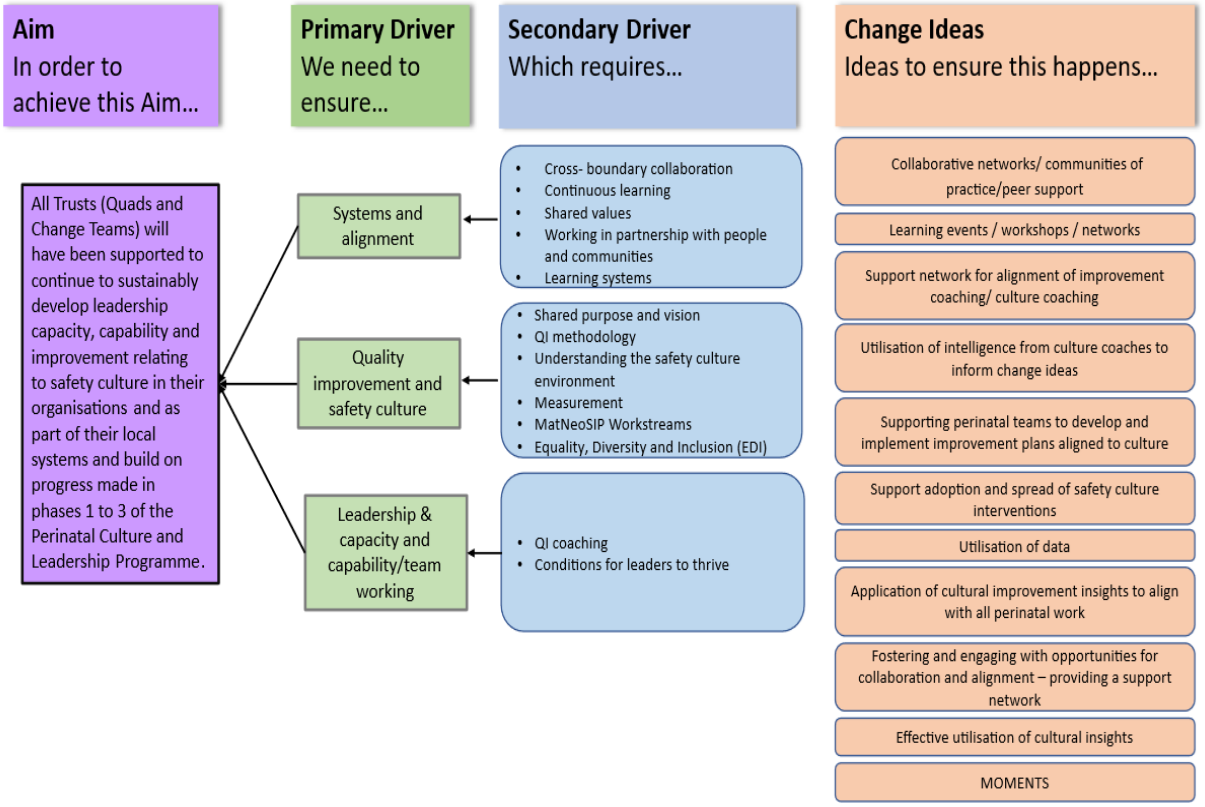
The phased work continued, with on-going leadership from the PCLP programme team at NHSE.

It was envisioned that integrating the PSC within the Health Innovation Networks, to provide support for the on-going culture and leadership development, would amplify the aims of the other Maternity and Neonatal workstreams currently delivered by the Patient Safety Commission as well as the System Safety (PSIRF) improvement programme.

Year 1 - 2024/25 driver diagram:



Year 2 - 2025/26 driver diagram:



Year two deliverables built on, and learnt from, the success of the first year of the PSC PCLP commissioned support whilst recognising the complexities of supporting safety culture improvements. During year two, the focus shifted from engagement with teams in the final processes of Phase 3, to progressing culture work, i.e., from analysis to active work to shift the culture and understand the impact of the work.

The programme recognised that measurement of culture is complex and must be meaningful to the local context.

To support engagement and sustainable planning of culture action plans with local organisations, the Health Innovation West of England PCLP leads aligned the workstream with the MIS Year 7 document —as compliance with this scheme provides significant financial reimbursement to organisations and therefore, supporting to evidence compliance will encourage initiatives to become embedded in local/regional practice.

To align the PCLP Specification Deliverables (2025–2026) with the MIS Year 7 Safety Actions, we mapped the PCLP deliverables to demonstrate direct correlation to, or support of, each of the ten MIS safety actions.

MIS Safety Action	PCLP Alignment
1: Use of PMRT for perinatal death review	• PCLP encourages cultural conversations and psychological safety, which can improve openness and accuracy in reviews like PMRT. • Culture Coaches facilitate trust-building which supports effective PMRT discussions and family engagement.
2: Submission to Maternity Services Data Set (MSDS)	• While not directly focused on data, PCLP's improvement culture indirectly supports better data collection by promoting accountability and communication across teams.
3: Transitional care and reducing separation	• MOMENTS and cultural improvement work can reduce mother-baby separation by improving multidisciplinary collaboration and care planning. • Engagement in cultural work may enhance pathway development and implementation.
4 & 5: Clinical and midwifery workforce planning	• Focus on compassionate leadership and sustainable change supports workforce morale and retention. • Culture Coaches and Quad teams promote understanding of safe staffing needs and escalate challenges constructively.
6: Compliance with Saving Babies' Lives Care Bundle (SBLCB v3)	• PCLP learning systems and MOMENTS support local improvement against SBLCB by encouraging reflection on care quality and actionable insights.
7: Co-production with women, parents, and families	• Culture Coaches and MOMENTS explicitly promote engagement with diverse voices, including marginalised and minoritised groups. • Supports the creation of inclusive, user-informed action plans following feedback like the CQC survey.
8: Multi-professional training	• Cultural support improves team dynamics and willingness to engage in multidisciplinary learning. • MOMENTS can be embedded within training to foster reflective practice.
9: Board oversight and safety intelligence	• PCLP fosters meaningful engagement between Board-level leaders and frontline teams through regular updates, learning systems, and feedback loops. • Emphasis on culture improves use and impact of tools like PQSM and PSIRF.
10: Reporting to MNSI and EN Scheme	• Encouragement of openness, psychological safety, and duty of candour through cultural conversations supports accurate and timely reporting. • MOMENTS can assist teams in recognizing and documenting qualifying incidents effectively.

MIS Safety Action	Description	Aligned PCLP Deliverables	Notes for Board / LMNS Reporting
1	Use of PMRT to review perinatal deaths	Cultural conversations, psychological safety, Culture Coaches, MOMENTS	Encourages open dialogue, thorough reviews, and family engagement. Supports staff to feel safe sharing insights during PMRT panels.
2	Submission to MSDS	Culture of accountability, engagement support	While indirect, improved team culture enhances data completeness and accuracy.
3	Transitional care and QI to reduce separation	MOMENTS, QI coaching, inclusive teamwork culture	Supports development and implementation of TC pathways through reflective practice and system collaboration.
4	Clinical workforce planning (obstetric, anaesthetic, neonatal)	Quad team leadership development, coaching support, MOMENTS	Leadership development supports sustainable staffing and clear responsibilities. Reinforces role clarity and rest provisions.
5	Midwifery workforce planning	Compassionate leadership, psychological safety, cultural engagement	Enhances team understanding of staffing needs, supports safe supernumerary roles and one-to-one care culture.
6	Compliance with Saving Babies' Lives v3	Learning systems, MOMENTS, coaching for QI plans	Fosters regular, reflective practice. MOMENTS supports discussion of clinical improvements.
7	Coproduction with families and MNVP action plans	Culture Coaches, inclusive engagement, EDI focus	Builds infrastructure for coproduction and responsiveness to user feedback (e.g., CQC Survey).
8	Multi-professional training compliance	MOMENTS integration, culture of learning, team safety focus	Enhances participation and retention in training through improved team cohesion and psychological safety.
9	Board oversight and use of safety intelligence	Learning systems, PQSM alignment, culture reports to Board	Facilitates robust Board discussions with cultural context, integrates PSIRF, and showcases learning outcomes.
10	MNSI & EN scheme reporting + family comms	Cultural conversations, duty of candour focus, psychological safety	Supports transparent, compassionate reporting and communication with families. Aligns with Regulation 20 duties.

Equity

Women racialised as Black and Brown, and those from wider Global Majority Ethnic backgrounds, are disproportionately affected by poor organisational and team culture within maternity and neonatal services.

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) consistently demonstrates stark inequalities in maternal and neonatal mortality and morbidity, with Black women in the UK significantly more likely to die during pregnancy, childbirth or the postnatal period compared with White women, and babies born to Black families experiencing higher rates of stillbirth, neonatal death and serious morbidity. These inequalities are not explained by biological difference, but by structural, institutional and interpersonal racism, compounded by unsafe cultures that fail to listen, respond or escalate concerns effectively.

MBRRACE-UK reports repeatedly identify contributory factors linked to poor culture, including failures in communication, dismissal of women's voices, inadequate recognition of clinical deterioration, and weak escalation pathways. Women from Global Majority Ethnic groups are more likely to describe not being heard, having their symptoms minimised, or experiencing delayed responses to deteriorating physical or mental health.

These experiences reflect cultures where psychological safety is low, hierarchies are rigid, and staff feel unable or unsupported to challenge decisions, raise concerns, or act decisively when risk is emerging.

Culture, Communication and Escalation

Poor organisational culture directly undermines safe communication and effective escalation. Evidence shows that communication failures within clinical teams are a leading contributor to adverse maternal outcomes, particularly for Black women, with omissions, lack of shared understanding and unclear accountability occurring more frequently in care episodes involving women from racialised groups. In environments where staff are over-stretched, fearful of blame or unsupported by leadership, early signs of deterioration may be missed or normalised, and women's concerns framed as anxiety rather than clinical warning signs.

Improving organisational and team culture is therefore a patient safety intervention in its own right. Cultures that prioritise psychological safety enable staff across all disciplines to speak up, share uncertainty, escalate concerns quickly and challenge decisions without fear of reprisal. These conditions support timely recognition of deterioration, appropriate senior review and coordinated responses to risk, which are critical to reducing preventable maternal and neonatal harm identified in MBRRACE-UK reviews.

Listening to women, particularly those from Black and Brown communities and wider Global Majority Ethnicities, is central to improving outcomes. MBRRACE-UK findings and qualitative research consistently show that women's concerns were often raised but not acted upon prior to serious harm or death. Unsafe cultures devalue women's knowledge of their own bodies, particularly where bias, stereotyping or assumptions about pain tolerance and resilience are present.

Culture change shifts this dynamic. When teams are trained and supported to practise culturally competent, person-centred care, communication with women improves, trust is strengthened, and risk is identified earlier. Valuing lived experience alongside clinical expertise creates safer care pathways and supports relational continuity, shared decision-making and respectful escalation.

Black Maternity Matters

The Black Maternity Matters programme, led by Health Innovation West of England in collaboration with Representation Matters, BCohCo and Black Mothers Matter, directly addresses the cultural drivers of inequity in maternity care. The programme recognises that Black women are disproportionately harmed by unsafe cultures and seeks to shift responsibility from individuals to systems and organisations. Through sustained, psychologically safe anti-racist education, peer support and quality improvement, the programme supports perinatal teams to examine how racism, bias and power dynamics shape communication, escalation and decision-making in everyday practice.

Black Maternity Matters aligns closely with the need identified in MBRRACE-UK to improve how services listen to and act on women's voices, and to embed cultural humility and accountability at senior leadership level. By supporting teams to translate learning into concrete quality improvement actions, the programme strengthens the cultural foundations required for safer, more equitable care for Black families and wider global majority populations.

Regional Perinatal Equity Network

The Regional Perinatal Equity Network, hosted by Health Innovation West of England in partnership with Health Innovation South West, provides a system-level forum to support culture change and collective learning across maternity and neonatal services. Its focus on psychological safety, cultural competency and community of practice mirrors the cultural conditions required to address the inequalities highlighted by MBRRACE-UK.

The network supports collaboration across professional, organisational and system boundaries, enabling teams to share learning, co-produce solutions with parent partners, and embed equity-focused quality improvement. By creating space for honest conversations about racism, bias and power in maternity care, the network reinforces the cultural shift needed to improve communication, escalation and listening to women's experiences across the region.

Year One of the PCLP Programme

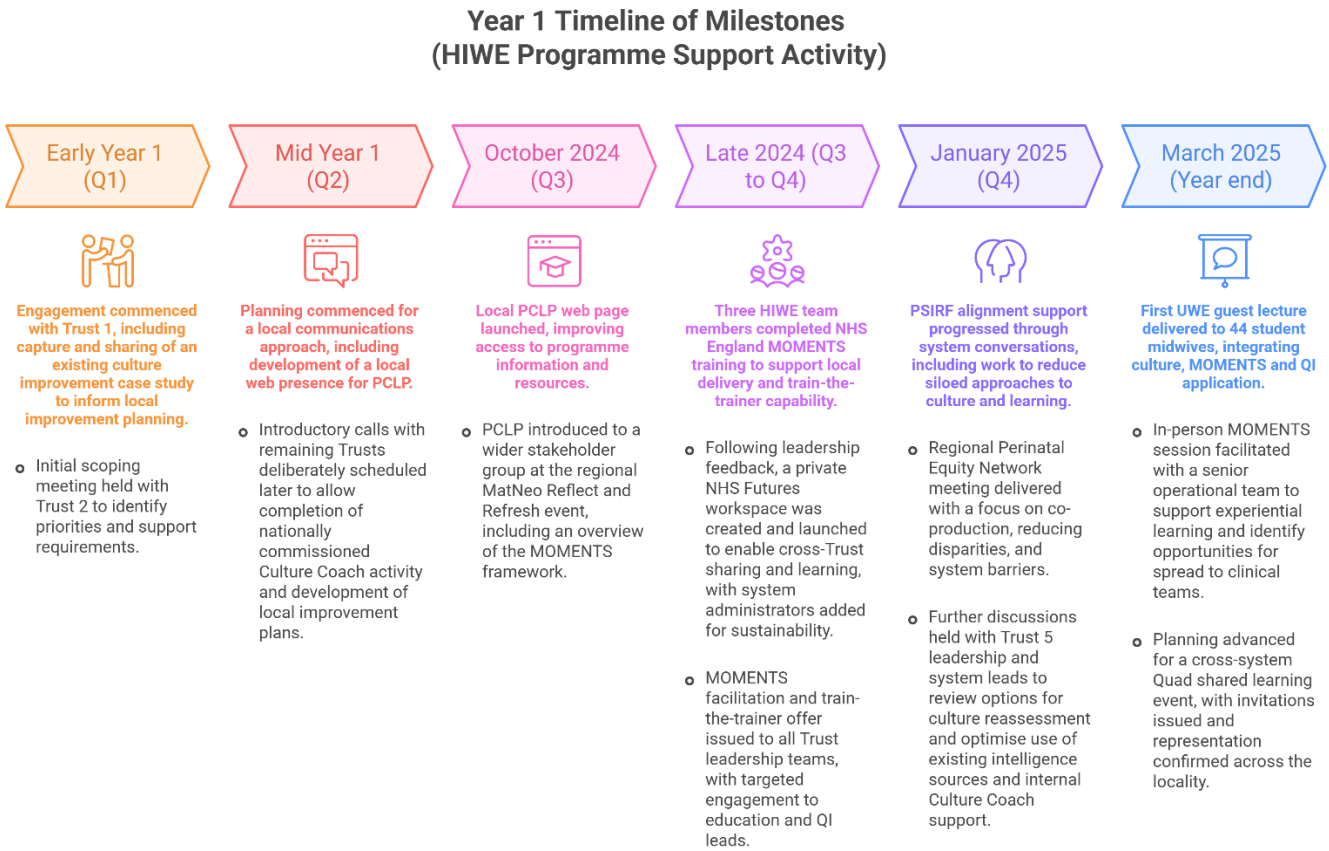
During year one, Health Innovation West of England provided system-level coordination, facilitation and sustainability support to embed the PCLP across maternity and neonatal services. The focus was on enabling local ownership of culture improvement, aligning PCLP activity with existing safety and improvement infrastructure, and creating practical mechanisms for shared learning across the locality.

In summary, year one delivery focused on:

- Building relationships with PLTs and tailoring support to organisational context.
- Increasing visibility and coherence through local communications and reporting alignment.
- Developing local capability to use the MOMENTS framework as a practical enabler for reflective learning and improvement.
- Establishing sustainable platforms for cross-site connection and shared learning.
- Strengthening alignment with PSIRF and wider system safety work.
- Supporting equity-focused learning through regional networks and co-production activity.

Trusts were at different stages of progress from the initial three phases of the PCLP, so delayed engagement with some of the local Trusts was both anticipated and accepted.

To minimise any assumptions about possible influencing system factors, we have referred to our organisations within the below as Trusts 1-5, rather than by organisational name.



Targeted Engagement and Tailoring of Support

Engagement began with Trust 1, where an established working relationship enabled early progress. HIWE supported the capture and sharing of a case study describing culture improvement work that had started prior to PCLP delivery. This case study provided a practical baseline and forms part of the Trust's emerging culture quality improvement plan as their projects develop. Early engagement also took place with Trust 2 to understand organisational priorities, clarify where targeted support would add value, and strengthen senior oversight.

Although the local improvement plan was not yet fully formalised, an early report was presented to the Trust Board, establishing visibility and accountability for culture-related activity.

Across the remaining Trusts, HIWE took a staged approach to introductory engagement in response to local leadership requests. Several sites asked to complete the nationally commissioned Culture Coach input first and to have improvement plans generated before engaging in broader system sharing. Follow-up engagement was scheduled to reflect local readiness and to maintain momentum without duplicating effort.

In parallel, HIWE held a further conversation with Trust 5 leadership and system partners to explore whether repeating culture measurement would be beneficial, given the time since the last survey. Acting as a critical friend, HIWE helped clarify what additional insight a new data set would provide when multiple intelligence sources already exist. The Trust was supported to make best use of existing tools already in place and encouraged to draw on internal culture coaching capability, including organisational development expertise.

Improved Visibility and Communication

To improve visibility and accessibility, HIWE developed and launched a local PCLP web page in October 2024. This created a single point of access for programme information and supporting resources. The programme was also introduced to a wider stakeholder group at a regional MatNeo Reflect and Refresh event, including an overview of the PCLP and the MOMENTS framework. This supported early system-wide awareness while recognising that many local teams were still finalising and socialising improvement plans with their clinical teams.

A significant emphasis in year one was building capability and ensuring sustainability. Three HIWE team members completed NHS England MOMENTS training to support local delivery and enable a train-the-trainer approach. Following feedback from Quad leaders that they wanted a practical platform to share improvement plans and learning across organisations, HIWE established a private NHS Futures workspace to support connection, shared learning and continuity. System colleagues were added as administrators to ensure the platform remains sustainable and transferable should commissioning arrangements change. Alongside this, HIWE extended a consistent offer to all Trust leadership teams to facilitate MOMENTS sessions and/or deliver train-the-trainer support, with targeted outreach to education and quality improvement colleagues to support integration into existing training curricula.

Embedding into Governance, Assurance and System Working

HIWE also worked to embed PCLP activity into existing governance and assurance structures. This included supporting inclusion of culture-related updates within routine Board reporting in Trust 3 and Trust 4, using existing 'Safe' reporting routes to avoid creating parallel processes. HIWE met with

system leaders to align PCLP outputs with current organisational reporting requirements, with the aim of streamlining work, reducing duplication and encouraging consistent sharing of progress across the locality. Further work was initiated to incorporate culture improvement and shared learning into system safety and quality meeting agendas, supporting coherence and momentum.

Alignment with PSIRF and Wider Safety Priorities

Alignment with the PSIRF and wider safety priorities was also progressed during year one. HIWE supported conversations across providers and system partners to reduce siloed approaches to culture and learning and to encourage consistent language and expectations across safety programmes. MOMENTS was socialised as a practical enabler for reflective learning and team-based sense-making, supporting PSIRF's emphasis on learning, improvement and psychologically safe engagement.

Workforce Development and Pipeline

Workforce development was strengthened through collaboration with pre-registration education. HIWE supported the integration of MOMENTS into a year two leadership and quality improvement module, and in March delivered the first guest lecture to 44 student midwives. The session provided insight into why perinatal culture is under increased focus, how senior leaders access staff perceptions of culture, and it facilitated a MOMENTS conversation that moved into "so what?" by linking culture insights to quality improvement methods and HIWE Academy resources to support students' QI proposal assignments.

HIWE also facilitated an in-person MOMENTS session with a senior operational leadership team within one organisation, enabling them to experience a facilitated culture conversation and consider where the approach could be implemented with clinical teams. The offer was extended across other clinical teams in the locality to support spread and consistency.

Indicative Year One Impact

Across the year, early signals of impact include improved Board-level visibility of culture improvement activity in multiple Trusts, strengthened system connectivity through a sustainable shared platform, and increased local capability to facilitate structured, psychologically safe culture conversations using MOMENTS.

Key risks recognised during year one included variable readiness and timing of local improvement plans due to completion of national Culture Coach input, and the potential for duplication of measurement and reporting burden. These risks were mitigated through staged engagement, follow-up scheduling aligned to local capacity, and critical friend support to clarify purpose and prioritise use of existing intelligence sources.

Year Two of the PCLP Programme

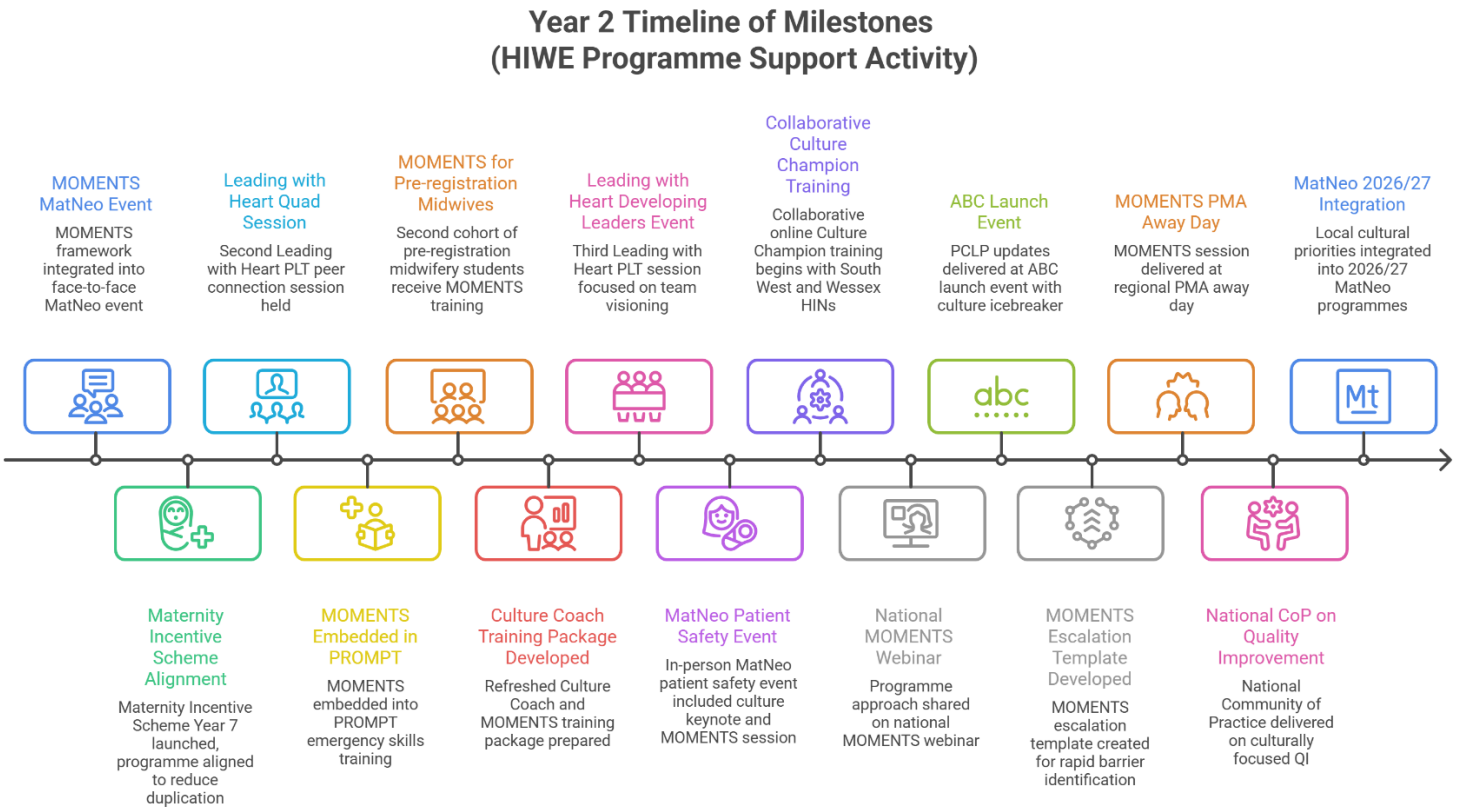
Year two of the PCLP built directly on the foundations established in year one of the commissioned PSC on-going support.

The focus deliberately shifted from diagnostic and analytical culture work towards active cultural change, practical application and understanding impact at team and system level.

The programme recognised that safety culture is complex, contextual and relational.

Rather than relying on isolated metrics, year two prioritised meaningful, locally relevant indicators, narrative intelligence and real-time feedback from multidisciplinary teams (MDTs). This enabled culture work to move from theory into daily practice.

A consistent theme across the year was sustainability —aiming to embed the programme and approaches into daily practice, conversations, and on-going QI initiatives. We achieved this through a train-the-trainer model, alignment with national and financial incentive frameworks, and embedding culture tools within existing education, quality improvement and safety processes.



Alignment with National Policy and Incentive Frameworks

To support engagement and ensure sustainability, year two delivery was explicitly aligned with the MIS Year 7 specification. This approach enabled Trusts to evidence culture work against mandated national requirements, particularly those with financial reimbursement implications.

Key actions included:

- Development of a logic model and alignment summary table mapping PCLP deliverables to MIS Year 7 requirements.
- On-going review of the MIS specification, with particular attention to safety actions 7–10, which have substantial culture evidence expectations.
- Early planning to support transition into MIS Year 8, recognising emerging expectations for dynamic, quarterly culture plans.

This alignment reduced duplication for Trusts and positioned culture work as a core enabler of operational, quality and safety priorities rather than an additional burden.

Progression from Culture Analysis to Culture Action

All five Trusts completed the original PCLP phases supported by Korn Ferry and presented their culture action plans either internally or through Local Maternity and Neonatal System (LMNS) forums.

Year 2 activity focused on:

- Supporting Trusts to activate and refine action plans.
- Translating cultural insights into behavioural, relational and system-level interventions.
- Supporting leadership teams to articulate clear cultural vision statements, with four of five Trusts doing so by the end of Quarter 2.
- Targeted engagement sessions were held with PLTs across Trusts 1–5 to identify progress, barriers and bespoke support needs.

Train-the-Trainer Model and Culture Coach Development

A key Year 2 deliverable was establishment of a sustainable Culture Coach model.

Culture Coach Strategy

We recognised that workforce movement had reduced the number of active Culture Coaches trained in year one. To support embeddedness and access to local Culture coaches, we asked PLTs across all Trusts to nominate new staff to attend training sessions, strengthening their organisational culture plans.

Following attendance at the NHSE Culture Coach training, the HIWE team developed a refreshed local Culture Coach and MOMENTS train-the-trainer package. This was piloted and refined using participant feedback.

Delivery Model

The offer comprised:

- Online training delivered as three one-hour sessions, four weeks apart (in collaboration with the neighbouring South West ad Wessex Health Innovation networks (HINs).

- A one-day face-to-face training with practical facilitation skills.
- On-going support and access to communities of practice.
- Bespoke on-site delivery aligned to local needs, including band 7 away days, mandatory training and team meetings.

This approach enhanced reach, consistency and sustainability across the system.

Embedding MOMENTS into Everyday Practice

The MOMENTS cultural conversations framework was a central mechanism for enacting and embedding culture change. See section on MOMENTS for the research and development of the tool.

Trust-Based Implementation

Through relationships established from previous work and the April 2025 MatNeo event, a programme of support was developed in collaboration with Trust 1. From experiencing the MOMENTS tool at the event, the perinatal education team saw an opportunity to integrate the conversation into their on-going PROMPT programme.

Trust 1 demonstrated sustained and deep embedding of MOMENTS through repeated use within PROMPT training and emergency drills, including shoulder dystocia scenarios.

Over the year, almost 300 MDT staff across Trust 1 received hands-on exposure to facilitated MOMENTS conversations, whilst the practice development and quality leads were supported to build confidence in facilitating post-incident and reflective conversations using a Being Fair (just and learning culture) approach.

Education and Mandatory Training

Education and Practice Development Leads across all five organisations engaged positively with opportunities to integrate MOMENTS into MDT mandatory training.

MOMENTS training was also delivered to second year student midwives at the University of the West of England, supporting early professional socialisation into psychologically safe practice. The 2-hour lecture includes cultural insights, and overview of organisational structures, including at system and region level, as well as QI approaches.

Within the lecture, a full hour of the session is utilised to objectively review practice and clinical experiences with peers, culminating in identification of possible opportunities for improvement, which the learners then go on to further develop into a QI proposal for their module assignment.

Reflections from the cohorts that have participated in the sessions to date demonstrate that they value the opportunity for reflection and how the tool supports them to apply critical thinking.

A sample of feedback from the cohorts so far includes:

- *"What was useful for me in this session was gaining a deeper understanding of what contributes to a positive safety culture, especially through a strengths-based approach that focuses on what is working well rather than solely on errors or incidents. I found it particularly helpful to learn that the process of engaging with colleagues—creating space for open dialogue, mutual understanding, and shared decision-making—is just as important as any plans or changes we develop. This reminded me of the value of giving everyone a voice*

and how involving the whole team in shaping safety culture can lead to greater innovation, ownership, and lasting improvement."

- *"(My main takeaway from the session was) Breaking down every day social practices in order to find the issues and (potential) resolutions to problems."*
- *"(My main takeaway from the session was) It made me think about questions I need to ask myself... Who needs to be involved in the change, what's happened or happening, can it just be slotted in or is there a whole culture change?"*
- *"(My main takeaway from the session was) It has made me question practice and think more critically about why things are done or not done and how they can be improved."*

Similarly, we led a MOMENTS session as part of a QI away day in collaboration with the NHSE South West Regional Maternal Team in March 2026. Within the session we introduced the MOMENTS tool and background, alongside the PCLP aims, objectives and approach.

The subject of the MOMENTS session was tailored to cover clinical deterioration and escalation, as the session included both Professional Midwifery and Professional Nursing Advocates (PMA/PNA).

Feedback of the main takeaway from the session included:

- *"The tea analogy at the beginning will be a great tool to use in Restorative Clinical Supervision, as well as the MOMENTS tool."*
- *"(MOMENTS is a) Useful framework to facilitate discussion. Will be a useful session to reflect on for my e-portfolio as I am a student PMA."*
- *"Cultural influences play a huge role in the success of QI, and implementation. This should not be underestimated."*

HIWE were fortunate to be the only HIN invited to share learning, approach and how we had utilised MOMENTS across the patient safety programmes, and in innovative forums, at a national webinar in December 2025, facilitated by the research team at the University of Leicester who developed the MOMENTS framework.

Leadership Development and Quad Engagement

Leading with Heart Programme

A series of *Leading with Heart* PLT peer connection sessions ran across the year, both virtually and face to face. Key themes included:

- Human connection and relational leadership.
- Inter-team communication challenges.
- Understanding individual working styles and needs.
- Intentional goal setting and values-based leadership.
- Subject matter experts supported sessions to deepen learning and peer reflection.

Attendance and engagement remained strong across all Trusts.

Developing Leaders Workshops

A dedicated face-to-face Developing Leaders workshop brought Quad and PLT members together to:

- Strengthen team cohesion.
- Explore succession planning.
- Develop achievable, values-led cultural goals.

These sessions directly contributed to clearer ownership and accountability for culture work at organisational level.

To support on-going development of the Quad and Perinatal Leadership Teams and provide an opportunity for the teams to connect away from the organisation, networking was encouraged within the Developing Leaders session, this was to both promote a shared appreciation for the challenges everyone faces and to share how the different organisations are approaching and overcoming these challenges.

Teams did an exercise mapping their current situation and reality and produced vision statements and cultural improvement action plans.

Vision Statements

Trust 1 - *"Within the next 12 months, we will see improved morale and alignment across our teams, reflected in positive staff survey results and feedback. Teamwork will be characterised by collaboration, respect, kindness, and honesty. Wellbeing will be strengthened through improved retention, reduced sickness rates, and greater uptake of rotational roles —creating a healthier, more sustainable workforce culture. This vision also includes a positive impact on service user experience, demonstrated by improved Friends and Family Test outcomes and stronger CQC service user feedback."*

Trust 2 - *"We are a cohesive, progressive perinatal service, nationally recognised for delivering equitable, compassionate, evidence-based care, driven by innovation and research. Our staff are well-trained, compassionate, and reflective of the communities we serve. We create a psychologically safe environment where all voices contribute to shaping services fit for the future. Service users are actively involved in design and feel listened to, happy, and healthy. Our leadership is visible, inclusive, and proactive, role-modelling compassion and shared purpose at every level."*

Trust 3 - *"We are a respected quad team who lead with courage and accountability. We work to clear roles and responsibilities, and we create a culture where people are empowered to find their own solutions. We challenge each other professionally and role-model the behaviours we want to see. By being brave and supportive, we strengthen morale, reduce stress, and foster an environment where respect and trust are the foundation for how we work."*

Trust 4 - *"Families feel valued, heard, and respected, receiving timely and responsive care that shows they truly matter. Staff feel proud to have delivered the standard of care they aspire to. Teams work cohesively, with compassionate relationships built on positivity, motivation, and shared values. Leaders are approachable, authentic, and effective — enabling others and role-modelling compassion and credibility. The culture supports speaking up and wellbeing, encouraging true work–life balance and self-care for all."*

Shifting Focus to Escalation and Deterioration

In line with emerging NHS England priorities, year two saw a planned shift in culture work to support detection of deterioration and escalation, aligning PCLP with:

- ABC (Avoiding Brain injuries in Childbirth),
- Maternal Early Warning Score (MEWS) and Newborn Early Warning Track and Trigger 2 (NEWTT2) implementation,
- Prevention, Identification, Escalation and Response (PIER) and Patient Safety Incident Response Framework (PSIRF).

Actions included:

- Development of MOMENTS templates specifically focused on escalation of deteriorating patients in perinatal settings, and cardiotocography (CTG) interpretation.
- Integration of cultural insights into ABC launch events and training.
- Design of scenario-based workshops focused on deterioration, response and human factors.

A locality survey on barriers to escalation was drafted to inform future years' work.

Site Visits and Organisational Intelligence

Targeted site visits to Trusts 1–3 provided valuable qualitative intelligence to shape on-going support.

Key cross-cutting themes from the conversations with clinical and leadership teams during these visits included:

- The importance of visible leadership behaviours.
- Gaps in feedback loops to staff following escalation or change.
- The need for clear governance ownership of "culture".
- Opportunities to celebrate improvement and rebuild morale.

These insights supported Trusts to prioritise actions that would deliver pace, visibility and credibility to culture improvement.

Case Studies and Knowledge Sharing

Several case studies were developed to evidence impact and share learning:

- *From Acorn to Oak*, demonstrating improved retention and support for early career midwives.
- Integration of MOMENTS into local multi-professional emergency skills training (Practical Obstetric Multi-Professional Training/ PROMPT).
- Continued integration of MOMENTS and cultural conversations in pre-registration Midwifery training to support the next generation of midwives to identify cultural challenges and respond through a QI lens.
- MDT community emergency skills training improving inter-organisational relationships.
- Exploration of professional perspectives and hierarchy in risk management.

These case studies are presented in full in the below section specifically on Case Studies.

Regional and National Collaboration

Year two activity extended beyond the five Trusts through:

- Collaboration with neighbouring Health Innovation Networks to deliver joint Culture Champion training.
  - This was delivered with our colleagues in the South West and Wessex Health Innovation Networks, through co-delivery of three 1-hour culture coach champion development sessions.
- Contribution to national MOMENTS webinars – including with the University of Leicester Research Team, demonstrating how, in the West of England we integrated MOMENTS across programmes.
- Participation in Civility Saves Lives maternity discussions.
- Delivery of a national PCLP Community of Practice session on culturally focused quality improvement.

This strengthened consistency, reach and influence of the programme.

Conclusion and Moving Forward

Year two of the PCLP demonstrated clear progression from engagement and analysis into sustained action, capability building and system integration.

Through alignment with national frameworks, development of local trainers, and embedding tools within education and safety infrastructure, the programme materially advanced psychological safety and cultural maturity across Trusts 1–5.

As PCLP transitions into the wider MatNeoSIP landscape, year two has ensured culture work remains visible, valued and firmly connected to the priorities of escalation, deterioration and patient safety outcomes.

Changes within the NHS Resolution MIS Year 8 Scheme have meant that Trust will continue to deliver an agile culture plan, with review at board-level at least 6-monthly; integration of thematic learning and deeper embeddedness of PSIRf and the cultural changes in the approach to patient safety management that the MOMENTS framework supports, and formal integration of the ABC programme has commenced, which encourages improved civility, communication and responses during clinical challenges to promote safer outcomes for mothers/pregnant people and their babies.

Due to the value, both locally and nationally, of the previous MIS Year 7 alignment, we aligned the on-going MatNeoSIP programmes for 2026—27 with the MIS Year 8 programme.

MIS Year 8 Alignment with 2026/27 PSC MatNeoSIP Specification

Maternity and Neonatal

MIS Year 8- Alignment with Health Innovation MatNeoSIP Programmes

MIS Year 8 Safety Action	What's Required?	Aligned MatNeoSIP programme deliverables	How engaging in the programmes can support MIS Year 8
A. Workforce and capacity	Board oversight of MDT workforce and capacity planning across maternity & neonatal teams; monitoring and escalation of persistent capacity issues (incl. planned CS pathway capacity mapping).	**MEWS/NEWTT2** implementation readiness explicitly requires multi-professional leadership and organisational readiness (incl. stakeholder groups and readiness work across leadership, staff readiness, governance, measurement, resources) to support safe deterioration response.	Use MatNeoSIP readiness activity to support evidence of role clarity, leadership structure, and workforce impact assessment for deterioration pathways (e.g., who responds, who escalates, how handover works). This strengthens the MIS A narrative (though staffing standards still need local workforce evidence).
B. Training	Board oversight of MDT training/competency (obstetric emergencies, fetal monitoring, neonatal resuscitation, in-situ simulation—hospital + community), with compliance checkpoints and reporting.	**MEWS and NEWTT2** require staff readiness and training planning, including improvement support where there are known issues with compliance/escalation/response. **ABC** requires cascaded training (faculty → T2 trust/site leads → T1 staff) and fidelity to approach; MIS B also explicitly expects IFH scenario inclusion by year end to align with ABC preparation.	Support evidence MIS B through: (1) MEWS/NEWTT2 training plan + staff trained counts; (2) case studies showing escalation behaviours improved (PIER); (3) ABC readiness—IFH scenario incorporated into MDT emergency training and/or simulation schedule; (4) board-ready training compliance trajectory with narrative on escalation practice.
C. Learning from reviews and investigations	Quarterly thematic learning reports triangulating national/local intelligence; "learning → action → impact"; parent involvement and robust governance.	MatNeoSIP expects measurement and local evaluation of MEWS/NEWTT2 implementation (e.g., compliance audits, staff trained, time to escalation case studies) within PIER. ABC includes feedback mechanisms ("share and learn"), phased implementation, and reporting routes, supporting systematic learning capture.	Integrate MatNeoSIP/ABC updates into MIS C quarterly thematic reports: include deterioration themes (missed recognition, delayed escalation, response delays), actions taken (training, pathway redesign), and evidence of impact (audit trends/case reviews). Use programme "share & learn" outputs as appendices or supporting evidence.
D. Service-user voice and equity	Service-user voice drives improvement; communication equity (language support/reasonable adjustments); use demographic insight to address inequities.	NEWTT2 escalation explicitly includes parent worry/concern and aims to improve parent/family experience within escalation pathways. MatNeoSIP expected outcomes include improved experience via engagement with women/families regarding escalating concern; triage scoping aims to reduce variation and improve triage systems.	Evidence MIS D by linking programme work to: 1. how women/families raise concerns in triage/postnatal/newborn settings and how staff respond; 2. co-designed patient information for escalation routes; 3. triage baselining that highlights equity gaps and improvement actions. Supplement with local interpreting/reasonable adjustment evidence as MIS D requires.
E. Care bundles	Board oversight of SBLCBv3.2 progress, plan for Maternal Care Bundle by March 2027, and neonatal pulse oximetry guideline including escalation pathways.	MatNeoSIP is not a care bundle programme, but it strengthens the escalation infrastructure (PIER, MEWS/NEWTT2) and measurement approaches that can be reused in bundle oversight reporting.	Use MatNeoSIP to evidence the "how" behind bundle safety: consistent escalation behaviours, reliable response pathways, and measurement discipline. For pulse oximetry, explicitly align escalation steps with PIER principles and newborn deterioration response culture supported by NEWTT2.
F. Board oversight, governance, culture and leadership	Board receives comprehensive maternity/neonatal safety intelligence; escalation routes; safety champions; MOSS critical safety checks/drills; culture improvement plan.	**MEWS/NEWTT2** implementation support includes explicit focus on guidelines/governance alignment, measurement, resources, and addressing escalation/response culture; also requires stakeholder and network engagement to sustain implementation. **ABC** includes defined support offer, reporting expectations, phased milestones, and escalation of barriers—all of which support board assurance.	Evidence MIS F by integrating MatNeoSIP/ABC governance into board cadence: adoption/spread narrative (MEWS/NEWTT2), readiness status, training progress, escalation culture risks, and barrier escalation. Use programme milestones and measurement plans as board assurance artefacts that show "active grip."

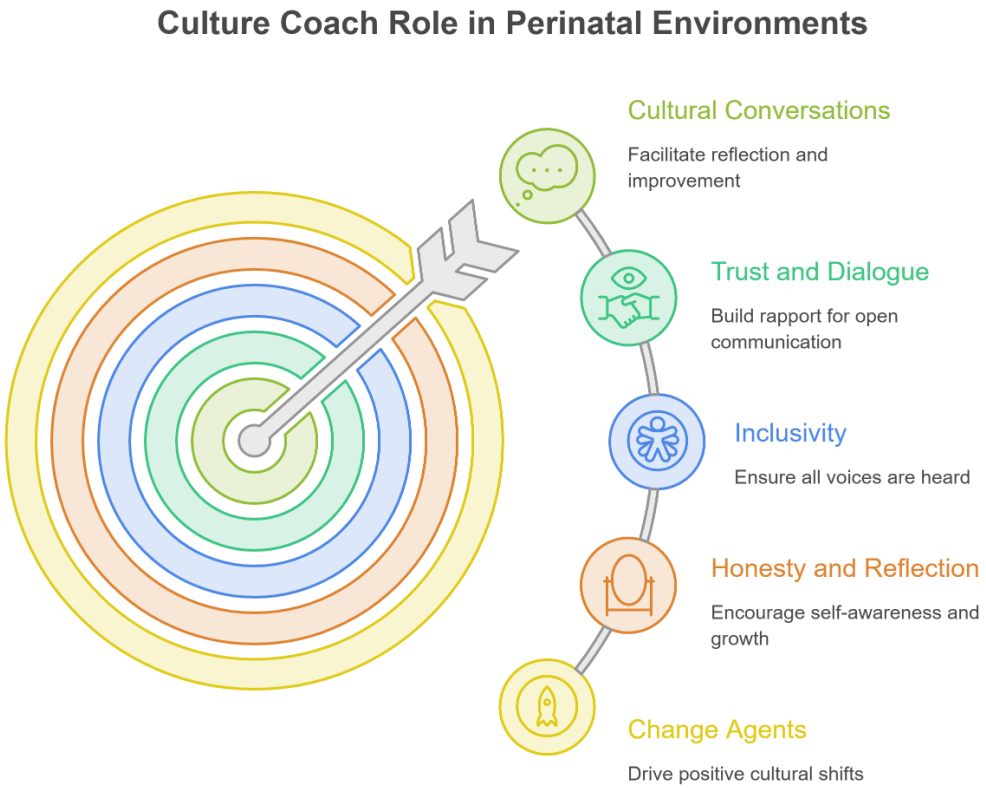
The Culture Coach Role: Enabling Culture Change in Practice

During year two of the PCLP, the Culture Coach role became a central mechanism through which culture work moved from analysis into meaningful, sustained action. As organisations progressed beyond diagnostic phases and into implementation, Culture Coaches provided the essential link between frontline experience and leadership decision-making, ensuring that culture improvement remained grounded in the realities of everyday clinical practice.

What is a Culture Coach?

At its core, the Culture Coach role is about creating the conditions for honest, reflective and inclusive conversations. Culture Coaches are not defined by hierarchy or seniority, but by their ability to build trust and facilitate dialogue. They are individuals who colleagues feel able to speak openly with, and who demonstrate a clear commitment to improving culture. In this way, they operate as credible and accessible agents of change within complex and often high-pressure perinatal environments.

The primary function of a Culture Coach is to facilitate cultural conversations. These are structured, yet flexible, discussions that bring staff together to reflect on their experiences of working within their service. Rather than focusing solely on problems or incidents, these conversations enable teams to make sense of their shared environment, explore different perspectives and identify opportunities for improvement. In doing so, they help to shift the narrative of culture from something abstract or difficult to define, to something that is tangible, visible and shaped through everyday interactions.



How does the Local Culture Coach and MOMENTS Training Pack Prepare Teams?

The training developed and delivered by HIWE, adapted from the NHS England 3-hour training session, during year two placed particular emphasis on the skillset required to hold these conversations well.

The HIWE Train-the-Trainer programme equips Culture Coaches with knowledge and practical skills across several domains, including:

- Understanding Culture and Safety
  - Including discussion which support exploration of the relationship between culture, leadership and patient outcomes, insights from national reports highlighting cultural contributors to harm, and recognition that culture is dynamic, relational and shaped in everyday interactions.

- Practical Facilitation Skills, within the local training we cover:
  - How to plan and lead cultural conversations,
  - Use of coaching techniques and appreciative inquiry,
  - Managing group dynamics and ensuring inclusivity, and
  - Navigating challenging topics such as hierarchy, bullying or racism.

- Use of the MOMENTS Framework
  - Running structured MOMENTS workshops,
  - Exploring everyday practices (e.g. handovers, escalation),
  - Identifying strengths and improvement opportunities.
- Translating Insight into Action
  - Capturing themes and generating improvement ideas,
  - Feeding back to leadership teams,
  - Supporting action planning and follow-up.

- Developing Others, instilling confidence to:
  - Train additional Culture Coaches,
  - Facilitate sessions independently, and
  - Support local sustainability.

Drawing on coaching methodologies, Culture Coaches are supported to adopt a stance of curiosity and neutrality, using questioning techniques that allow individuals and teams to explore issues in depth rather than being directed towards predefined solutions. This approach encourages collective ownership of both the challenges and the responses, strengthening engagement and increasing the likelihood that improvements will be meaningful and sustained.

A foundational component of this work is the creation of psychological safety. In environments where staff may feel hesitant to speak up due to hierarchy, workload pressures or fear of blame, the Culture Coach plays a critical role in modelling behaviours that promote openness, respect and inclusivity. Through skilled facilitation, they create spaces in which staff feel heard and valued, enabling more honest dialogue and richer insight. This is particularly important in perinatal services, where national reviews have repeatedly highlighted the impact of poor communication, lack of psychological safety and unresolved tensions between professional groups.

Benefits and Impact of the Local Culture Coach Training

This focus on the 'everyday' has been particularly powerful in year two, supporting teams to recognise that culture is not only revealed in times of crisis, but is continuously created through small interactions, behaviours and decisions. As a result, cultural improvement becomes less about implementing discrete interventions and more about shaping how work is done on a daily basis.

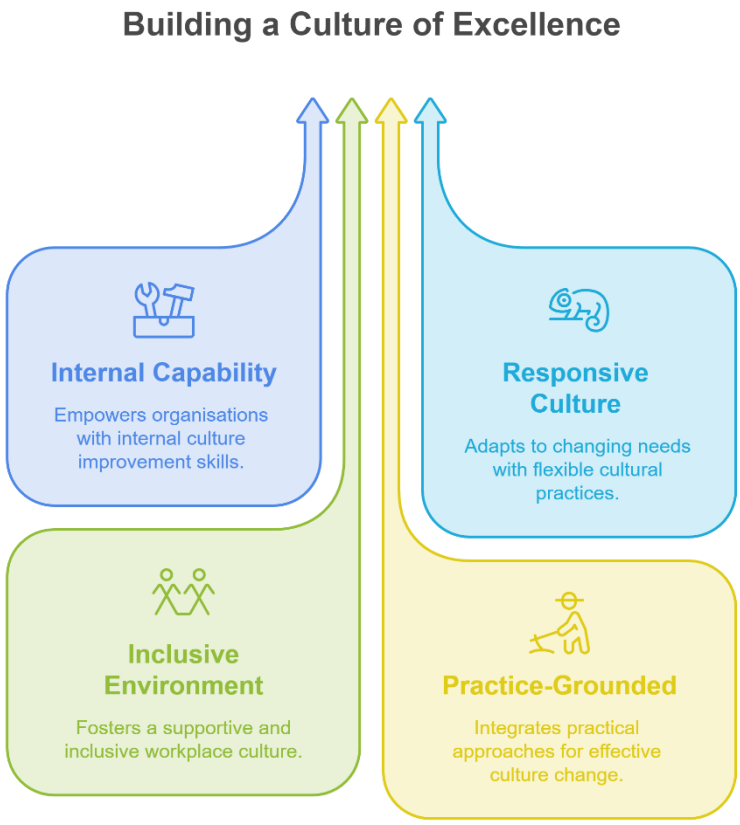
The locally developed Culture Coach and MOMENTS train-the-trainer package has been a key enabler of this shift. Designed to reflect both national programme requirements and local service needs, the training equips individuals with a comprehensive understanding of culture, patient safety and facilitation skills, alongside the confidence to apply these in practice. Importantly, it also prepares Culture Coaches to train others, supporting the development of a sustainable network of facilitators within organisations.

This locally tailored approach has offered significant advantages.

- By embedding training within the locality context, it ensures that content is directly relevant to the challenges faced by teams, increasing engagement and applicability.
- It also reduces reliance on external support, allowing organisations to maintain momentum despite workforce changes and competing priorities.
- As seen during year two, where turnover among previously trained Culture Coaches was identified, the ability to rapidly train new individuals has been essential in sustaining progress.

Crucially, Culture Coaches have helped to ensure that culture work is not experienced as an additional task, but as an integral component of safe and compassionate care. By embedding reflective practice into everyday work, they have contributed to a shift towards a more continuous, learning-focused approach to improvement.

Through locally developed training, integration of the MOMENTS framework and strong alignment with system priorities, Culture Coaches have enabled culture to be understood, discussed and improved in the context of everyday clinical work.



As the PCLP moves beyond its initial programme structure and becomes integrated within wider MatNeoSIP workstreams, the Culture Coach model represents a lasting and sustainable legacy.

It provides organisations with an internal capability to continue exploring, understanding and improving culture in a way that is responsive, inclusive and grounded in practice. Through this, Culture Coaches will continue to play a vital role in shaping environments where staff feel supported, voices are heard and the conditions for safe, high-quality care are consistently strengthened.

MOMENTS Framework: Conversations to Support Cultural Change

The MOMENTS framework (Meanings, Competencies and Materials in Everyday Team Safety) is a practical, evidence-informed approach to understanding and improving safety culture through everyday clinical practice. It was developed through research led by the SAPPHIRE group at the University of Leicester, in collaboration with NHS England and the National Institute for Health and Care Research (NIHR) Greater Manchester Patient Safety Research Collaboration.

The research underpinning the framework explored what characterises high-performing safety cultures in maternity and neonatal services. Importantly, this work moved away from traditional approaches that focus primarily on incidents, errors or deficits. Instead, it adopted a positive enquiry methodology, examining what works well in practice and how these strengths can be amplified.

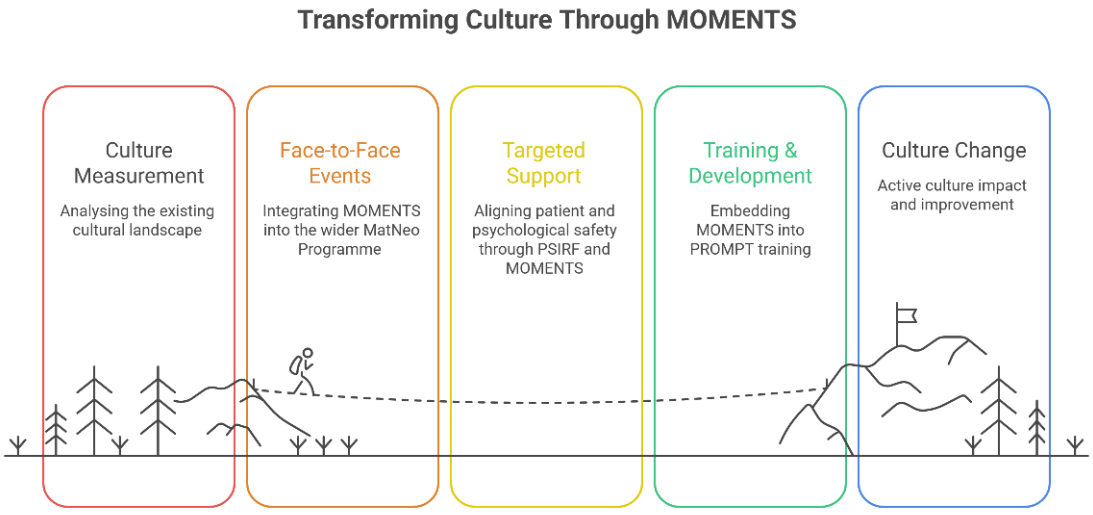
From this work, safety culture was reconceptualised as something that is not simply measured through surveys or embedded within policies, but rather produced and reproduced through everyday practices, relationships and interactions. The framework therefore provides a structured way to examine routine activities, such as handovers, escalation, or informal team interactions, as a "window" into how culture is enacted locally. (NIHR, 2024)

At its core, MOMENTS focuses on three interconnected elements:

- **Materials**: the tools, resources and environment that shape practice
- **Competencies**: the knowledge, skills and capabilities of staff
- **Meanings**: the social norms, values and beliefs that underpin behaviour

In practice, the MOMENTS framework is implemented through facilitated, structured conversations and workshops, often led by trained Culture Coaches or facilitators. These sessions are intentionally designed to be interactive and reflective, rather than directive.

MOMENTS supports a "safety culture-as-practised" approach, meaning that it focuses on real work as it is experienced by staff, rather than "work as imagined" through policy or guidelines.



Within year two of the PCLP, this has been demonstrated through:

- Integration of MOMENTS into routine training and simulation,
- Use of structured conversations to explore escalation and deterioration,
- Application of the framework to generate locally relevant quality improvement actions.

Importantly, the framework is not a one-off intervention. It is designed to normalise on-going reflective dialogue, enabling cultural conversations to become embedded within everyday practice and team interactions.

Why Use the MOMENTS Framework?

The implementation of MOMENTS has demonstrated several key benefits, both in the research evidence and through programme delivery.

- Making Culture Tangible and Actionable
  - One of the primary strengths of MOMENTS is its ability to translate culture from an abstract concept into something visible, discussable and actionable. By focusing on everyday practices, teams can clearly see how behaviours, systems and values interact, making it easier to identify meaningful improvements.

- Strengths-Based and Engagement-Focused
  - Unlike traditional safety approaches, MOMENTS adopts a strengths-based methodology, encouraging teams to build on what works well rather than focusing solely on failure. This supports:
    - ✓ Greater staff engagement,
    - ✓ More balanced and constructive conversations,
    - ✓ Increased motivation for change.

- Enhancing Psychological Safety and Team Reflection
  - The facilitated conversational approach enables open discussion across hierarchical and professional boundaries, supporting:
    - ✓ Improved psychological safety,
    - ✓ Stronger multidisciplinary relationships,
    - ✓ Increased willingness to speak up and share perspectives.

- Generating Context-Specific Improvements
  - By examining real practices in real settings, MOMENTS produces locally relevant insights and practical actions, rather than generic recommendations. This increases the likelihood that improvements will be implemented and sustained.

- Supporting Continuous Learning
  - MOMENTS promotes a shift from episodic review to continuous reflection and learning, where teams regularly revisit and refine their practice. This aligns closely with modern patient safety principles and improvement science.

Alignment of MOMENTS with the Patient Safety Incident Response Framework

The MOMENTS framework aligns strongly with the principles underpinning the Patient Safety Incident Response Framework (PSIRF), which emphasises a move towards systems-based, learning-focused approaches to safety.

PSIRF represents a significant shift from investigating "what went wrong" to understanding how and why incidents occur within complex systems, with a focus on learning and improvement rather than blame. MOMENTS complements this approach in several ways:

- By exploring materials, competencies and meanings, MOMENTS enables teams to examine the wider system factors influencing practice, aligning with PSIRF's emphasis on understanding contributory factors within complex socio-technical systems – aligned with a systems thinking approach.

- PSIRF encourages organisations to look beyond individual incidents and consider broader safety themes. MOMENTS directly supports this by focusing on everyday work as the primary source of learning, rather than isolated events. This aligns with the Safety II approach.

- MOMENTS can be used alongside PSIRF methodologies such as After Action Reviews or thematic learning responses to:
  - Provide richer contextual insight,
  - Capture staff experiences and perspectives,
  - Inform more meaningful and sustainable safety actions.

- Both PSIRF and MOMENTS prioritise the involvement of staff in learning processes. The conversational, inclusive nature of MOMENTS supports compassionate engagement and collective sense-making, which are central to PSIRF principles.

This alignment, enabled us to integrate the MOMENTS tool into the Quality and Safety section of the PROMPT programme at one our local organisations, supporting a shift towards embedded, relational and sustainable culture improvement, ensuring that safety is not only addressed in response to incidents, but continuously shaped through the everyday actions, behaviours and interactions of teams.

Sustaining Culture and Safety: The Legacy of the Perinatal Culture and Leadership Programme

The legacy of the Perinatal Culture and Leadership Programme is demonstrated through:

- The integration of culture into everyday clinical and safety practice,
- The development of local capability and leadership through Culture Coaches,
- The use of practical tools, such as MOMENTS, to generate actionable insight,
- Strong alignment with PSIRF and system-wide approaches to learning and improvement,
- And continued relevance to national safety programmes and priorities.

Together, these elements provide a robust and enduring foundation for sustained improvements in safety culture, ensuring that the experiences of staff, women, babies and families remain at the centre of ongoing improvement efforts.

The Perinatal Culture and Leadership Programme (PCLP) has, over its duration, moved beyond being a discrete programme of work and has instead established a sustainable infrastructure for ongoing culture and safety improvement across perinatal services. The combination of Culture Coach development, the embedding of the MOMENTS framework and alignment with national safety programmes has created a lasting legacy that will continue to influence both behaviour and outcomes.

The legacy of PCLP lies in the normalisation of culture as an everyday component of safety, rather than an abstract concept or time-limited initiative. Through the systematic integration of cultural conversations into education, simulation, incident response and quality improvement activity, teams have developed the capability to continuously reflect on and improve how care is delivered. This has shifted the focus from reactive, episodic responses to incidents towards a proactive, learning-focused culture, aligned with modern patient safety principles.

ABC and MatNeo Escalation and Deterioration Programme Alignment 2026/27

A key element of this sustainability is the embedding of the MOMENTS framework within clinical practice, particularly through its adaptation to high-priority safety areas such as escalation and deterioration.
The locally developed ABC MOMENTS worksheets demonstrate how this framework has been operationalised to support frontline teams to unpick the complexity of safety-critical scenarios. For example, in perinatal deterioration, teams are supported to consider not only clinical observations but also wider influencing factors such as communication, staffing, fatigue, equipment, system biases and escalation pathways.
Similarly, in CTG escalation, the framework highlights the interplay between technical knowledge, situational awareness, team culture, hierarchy and confidence to escalate.

These tools exemplify how the programme has moved culture work into real-time clinical decision-making, ensuring that safety is understood as a product of both technical competence and relational, contextual and behavioural factors. This integration provides a strong foundation for sustained impact, as it aligns directly with the priorities of the Maternity and Neonatal Safety Improvement Programme, particularly in relation to escalation, detection and response to deterioration through MEWS, NEWTT2 and intrapartum safety (ABC programme).

The Culture Coach model further underpins this legacy by creating a distributed leadership approach to culture improvement. By developing individuals within organisations who are skilled in facilitating reflective, psychologically safe conversations, the programme ensures that cultural insight continues to be generated and acted upon. Importantly, the transition to a train-the-trainer model supports resilience to workforce changes and enables ongoing spread without reliance on external facilitation.

System Safety 2026/27

The sustainability of the programme is further strengthened through its explicit alignment with the Patient Safety Incident Response Framework (PSIRF) and the associated Insight to Improvement approach (2026/27 programme of work). This work moves beyond the implementation of PSIRF as a policy requirement and focuses on developing the infrastructure required to ensure that learning from incidents is consistently translated into meaningful improvement.
The PCLP has directly contributed to this by:

- Enhancing organisational capability to surface and interpret qualitative cultural insight alongside quantitative data,
- Strengthening connections between frontline teams, leadership and safety governance structures,
- Supporting the development of coherent systems that link learning responses to improvement actions.

Through the continued development of regional safety and improvement networks, and the establishment of shared approaches to measurement and evaluation, this work ensures that culture is embedded within system-level safety management, rather than existing as a parallel activity.

On-Going Sustainability

Looking forward, the on-going legacy of PCLP is further reinforced through its alignment with current and emerging national safety priorities.

The programme's methodologies and outputs directly support:

- The continued implementation and embedding of MEWS and NEWTT2, by addressing the cultural and behavioural factors that influence recognition and escalation of deterioration,
- PERIPrem and perinatal optimisation, through strengthened multidisciplinary collaboration and shared understanding of best practice,
- The implementation of Martha's Rule, by reinforcing psychological safety, communication and escalation behaviours across teams,
- Emerging workstreams focused on sepsis, where early recognition, communication and escalation are similarly dependent on strong safety culture.

Across these areas, the MOMENTS framework and Culture Coach model provide a consistent, adaptable methodology for exploring the human and system factors that underpin safe care.

Crucially, the programme has also established the conditions for continuous improvement and learning beyond its formal lifespan.

By embedding culture within governance structures, aligning with incentive frameworks and integrating into existing education and training provision, PCLP has ensured that culture is not only sustained but continues to evolve in response to local and national priorities.

Case Studies & Blog Posts, followed by Programme Resources

Blogs

- Breaking down barriers for safer systems: a day of inspiration, innovation and insight - Health Innovation West of England
  - This blog, written by Registered Midwife Senior Project Manager Jenn Garner reflects on a regional learning event that brought together perinatal teams to share innovation, strengthen collaboration and explore how culture and leadership can drive safer systems. It highlights the collective commitment across organisations to break down barriers, amplify learning and embed approaches such as MOMENTS and culture-based improvement to enhance outcomes for women, babies and families.

- Why safety culture needs more than policies - Health Innovation West of England
  - This post was written by Registered Midwife Senior Project Manager Gill Travers, focusing on how improving safety culture in perinatal care requires more than policies alone, this blog highlights the need to focus on everyday behaviours, relationships and real-world practice. It demonstrates how embedding approaches such as the MOMENTS framework within education can support a more human-centred, strengths-based and sustainable shift in culture and safety.

- Why Martha's Rule matters - Health Innovation West of England
  - This reflective post by Senior Project Manager and Critical Care Nurse Siobhan Lanigan explores the implementation of Martha's Rule as a critical patient safety initiative, emphasising the importance of listening to and acting on the concerns of patients, families and staff to prevent deterioration and avoidable harm.
    It aligns closely with the Perinatal Culture and Leadership Programme by reinforcing the central role of psychological safety, open communication and flattening hierarchy in enabling timely escalation and safer, more responsive care.

- Beyond the call: Martha's Rule in action - Health Innovation West of England
  - This further post from Siobhan captures learning from a regional Martha's Rule in Action event, bringing teams together to share experiences, celebrate progress and strengthen collaboration in improving escalation and response to deterioration. It highlights how creating psychologically safe, inclusive cultures where all voices are heard is essential to patient safety, reinforcing key principles of the Perinatal Culture and Leadership Programme around leadership, speaking up and culture as the foundation for safer care.

- In conversation: Jan Scott, Senior Programme Manager – Patient Safety - Health Innovation West of England
  - This personal reflection from Senior Programme Manager, Patient Safety Lead Jan Scott demonstrates how the patient safety programmes are interconnected as they have elements of culture shift to embed change and require psychological safety, clear communication across teams to support safer patient care.

The following pages contain case studies which demonstrate work throughout the PCLP in collaboration with our local Perinatal Services.

Perinatal Culture

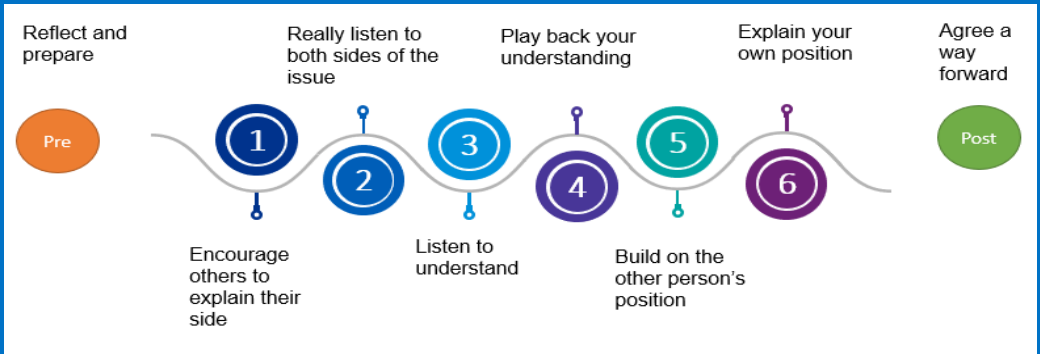
Great Western Hospitals NHS
NHS Foundation Trust

Great Western Hospitals NHS Foundation Trust provides maternity care to women in Swindon and surrounding rural areas, and approximately 4,000 babies are born here each year. The Trust is part of Bath and North East Somerset, Swindon and Wiltshire Local Maternity and Neonatal Service.

In October 2021, the staff survey raised concerns around organisational/departmental culture.
In February 2022, all Maternity staff were sent a confidential Culture of Care survey to provide more feedback – this was achieved via 104 response to the survey and 36 staff attending focus groups. A Maternity staff forum, led by the Chief Nurse was held to discuss the findings and identify the next steps.

Approach

- Session held on Band 7 away days with opportunity to role play.
- Empowering impact on willingness to facilitate conversations that might have previously been labelled as 'difficult'.
- Sense of pride when undertaken which empowered shared learning and experiences.
- Sustained use of the language 'courageous conversation' now looking to transition to 'compassionate conversation' holding same principles.



Resources

- Support has been received by the Trust organisational Development team to facilitate cultural away days with the senior team, with a focus on leadership and challenging poor behaviour.
- Training capacity to embed Learning Together methodology.

Challenges

- CQC inspection of Maternity services September 2023, immediate changes implemented in response to CQC feedback October 2023.
- Integrating on-going culture work into development of CQC improvement plan Nov 2023.
- CQC report published immediately prior to Safety, Culture, Operational risk, Resilience/burnout and Engagement (SCORE) survey being sent out to staff.

Impact

- Strengthened senior team at matron level over the last 6 months provides improved visibility of the leadership team and oversight.
- Strengthened clinical leadership model for Obstetrics and Gynaecology to include a deputy clinical lead with focus on Obstetrics.
- Feedback from the safety champions walkabouts have demonstrated an improvement in the culture and moral described by the teams.
- Third cohort of Maternity & Neonatal service staff participating in Trust Improving Together training to embed methodology and practices throughout the workforce.

Next Steps

The Trust is actively engaged with the NHS England Perinatal Culture and Leadership Programme.
The SCORE survey closed in April 2024 with culture conversations planned from July 2024.

Service Teamwork Ambition Respect

Produced in collaboration with West of England Patient Safety Collaborative

Maternity and Neonatal

Weaving the Cultural Thread

How the Perinatal Culture and Leadership Programme (PCLP) strengthens wider cultural development across the Patient Safety Commission (PSC)

April 2025

Health Innovation West of England

Over the last 10+ years, there have been several major independent investigations into serious harm caused by maternity and neonatal services: University Hospitals of Morecombe Bay NHS Foundation Trust, Shrewsbury and Telford Hospital NHS Trust and East Kent Hospitals University NHS Foundation Trust.
Overarching themes from all these reports are:

- Poor working relationships, particularly between different staff groups, with the East Kent report citing “a culture of tribalism and poor working relationships between different staff groups, particularly between midwives and obstetricians”.
- Lack of patient-centred care and a lack of attention to patients' needs and concerns, including a reluctance to engage with families in investigations.
- Failure to learn from past incidents, with some families being unaware that investigations into their care had taken place.



The wider PSC programmes all have elements relating to the themes identified in the national maternity reports, with the **Medicines Safety Improvement Programme** focusing on reducing harm from opioids, a key theme that has emerged from patient engagement is a deficit in patient-centred care and lack of attention to patients’ needs and concerns – with research demonstrating that people seeking support from health and care professionals for their chronic/persistent pain conditions want sign-posting to self-management options and not necessarily a prescription.

Similarly, the **Martha’s Rule** programme is facilitating shared learning across the locality as organisations pilot implementation of local processes when patients/families/carers and staff are worried about a patient's deteriorating condition – again developed from an overarching theme of a lack of attention to patients’ needs and concerns in conjunction with poor working relationships and failure to learn from past incidents.

To further support a focus on the golden thread of safety culture, the **System Safety** programme has been focused on supporting providers and systems to implement and embed the Patient Safety Incident Response Framework (PSIRF), with a shift in focus from level of harm of a patient safety incident to a focus on the learning that can be achieved to improve future care.

By encouraging health and care teams to pilot and embed the tools/approaches from the PCLP, there are opportunities to promote and develop positive working relationships not only between different staff groups, but across organisations/providers, including developing the role of the Culture Coach. Culture Coaches empower individuals in teams/departments/organisations to engage peers through conversation, collaborate better across silos and reduce incivility by cultivating a supportive environment that prioritises open communication and psychological safety.

To further support alignment of the workstreams, the MOMENTS framework has been shared with all Quality and Safety Leads across the geographical region with an offer for train-the-trainer sessions with their teams as this framework supports discussions which align with the PSIRF After Action Review learning response. Embedding PSIRF effectively will help address the themes of ‘failing to learn from incidents’ and ‘reluctance to engage with families in investigations’ as patient/family engagement is a key area of the learning response and development of improvement actions to reduce the chance of repeat incidents – with the language within both PSIRF and the PCLP reinforcing that continuous improvement is the key to successfully crafting the conditions for a positive safety culture.

Maternity and Neonatal

Embedding the MOMENTS Framework in Midwifery Education: Shaping Safety Culture through Everyday Practice

October 2025

MOMENTS graphic used with consent from University of Leicester

University of the West of England, BRISTOL

in association with Health Innovation West of England

Through collaboration between the University of the West of England and Health Innovation West of England, the MOMENTS Framework was embedded into the Year 2 Pre-Registration Midwifery module. The session enabled student midwives to explore how everyday actions and shared values shape maternity safety culture. The collaboration supported the Perinatal Culture and Leadership Programme (PCLP) ambition to create compassionate, equitable, and learning-centred maternity environments. HIWE have been invited back to facilitate the session again with the next Year 2 cohorts in session that will be held in March 2026 and July 2026.

Maternity services in England have faced significant safety challenges, highlighted by reports such as Ockenden and East Kent. These identified that service users' voices were not heard, and staff felt unsupported. In response, NHS England's Three-Year Delivery Plan for Maternity and Neonatal Services (2023) called for a compassionate, learning-oriented culture shift.

At UWE, the opportunity was identified to prepare future midwives to lead that change in partnership with Health Innovation West of England. The aim was to embed cultural learning early in professional development by integrating the MOMENTS framework into the midwifery curriculum, connecting safety culture theory with quality improvement (QI) and leadership in practice.

In October 2024, a new two-hour lecture with practical workshop elements was co-developed by the Health Innovation West of England Perinatal Culture and Leadership Programme workstream lead following a conversation with one of the University of the West of England Midwifery lecturers. These sessions were facilitated for both Year 2 cohorts, with the first session taking place in March and the second being held in August 2025.

Drawing on the MOMENTS framework and QI methodology, the session enabled students to:

- **Reflect on everyday practices** (e.g. handovers, huddles, or making tea)
- **Explore how values such as compassion, civility, and trust are enacted**
- **Understand the power of dialogue and shared decision-making in shaping culture**
- **Connect individual leadership behaviours with system-level improvement**

Interactive exercises guided students through MOMENTS' social practice lens (competencies, meanings, and materials). The workshop mirrored Patient Safety Collaborative led approaches to cultural improvement, encouraging curiosity, reflection, and psychological safety.

The main **challenges** were:

- Translating an abstract concept like "culture" into practical learning activities
- Ensuring relevance to learners with limited clinical experience
- Balancing theoretical learning with the practical demands of a packed academic curriculum

The session was well received, and qualitative feedback demonstrated strong engagement and learning impact. **Learners described gaining:**

- **A deeper understanding** of what contributes to positive safety culture
- **Confidence** to speak up and participate in cultural change
- **Insight** into systems that support safe, compassionate maternity care

"What was useful for me in this session was gaining a deeper understanding of what contributes to a positive safety culture, especially through a strengths-based approach that focuses on what is working well rather than solely on errors or incidents."

Learners described feeling empowered to act as advocates for women and families, **and as contributors to improvement from early in their careers**.

They reported:

- **improved understanding of leadership roles,**
- the **importance of reflection**, and
- **how small actions can influence cultural change**.

"This session allowed me to gain an understanding of the systems available and the process behind MOMENTS conversations in maternity care… and how I can contribute to cultural improvements."

What were the learning points?

- Embedding cultural learning in education helps bridge the gap between theory and practice.
- Focusing on everyday social practices makes "culture" visible and discussable.
- Creating psychological safety in learning environments encourages openness and critical reflection.
- Using MOMENTS as a framework enables structured, compassionate conversations about safety, voice, and improvement.

Maternity and Neonatal

Improvement Project: 'From Acorn to Oak' – Improving Newly Qualified Midwife Support, Wellbeing and Job Satisfaction to Reduce Early Career Midwife Leaver Rates

Project Lead: Kate Giles, Education & Workforce Development Lead for Maternity & Neonatal Services - Great Western Hospitals NHS Foundation Trust

Date: January 2026

NHS Great Western Hospitals NHS Foundation Trust

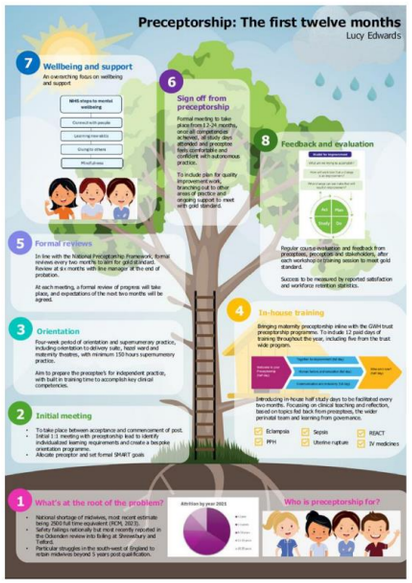
in association with Health Innovation West of England

Early career midwife attrition at the Trust was significantly above peer benchmarks, with the 0 to 1 year leaver rate at 13.% and 12-month rolling turnover averaged 9.5%. Newly Qualified Midwives (NQMs) reported low confidence, limited support and reduced wellbeing.
This project aimed to reduce early career midwife leaver rate below peer median and improve NQM satisfaction, support, competence and wellbeing by at least 50% within 12-months, through a structured preceptorship programme and dedicated Lead Preceptorship Midwife. The project was launched in September 2024 and evaluated after 12-months.

Prior to the project, the Trust had:

- An opportunity to develop a structured preceptorship programme.
- Identified that early career support could be strengthened through a dedicated leadership role.
- Preceptorship allocation and protected time, but recognised that there was an opportunity for it to be more consistent to enhance the experience.
- Identified the need to address MDT pressures- which would provide potential to strengthen the learning culture, and psychological safety.

These factors created an opportunity to strengthen ownership and coordination of preceptorship, enhance cultural consistency across the MDT, and develop more effective feedback mechanisms to identify unmet needs. Addressing these areas will better support individuals as they transition from student to autonomous practitioner, helping to reduce anxiety and improve retention.



Key Learning

- **A whole-team approach to culture change is essential**, ensuring that support extends beyond the preceptor to the entire multidisciplinary team.
- **Protecting time for learning is crucial for maintaining psychological safety** and enabling meaningful development.
- While quantitative data provides strong evidence of progress, **qualitative feedback offers important context by humanising the impact** and deepening cultural understanding.
- **Sustaining a positive culture also relies on leadership training and the promotion of civility.**
- **Clear communication and well-defined expectations help reduce anxiety** during the transition period, creating a more supportive and stable environment for early career midwives.

"I feel very supported and am grateful to have been given the protected super numeracy time."

"The preceptorship has helped me identify areas that I need to cover clinically - the preceptorship pack is clear and easy to follow, having this in place provides great support."

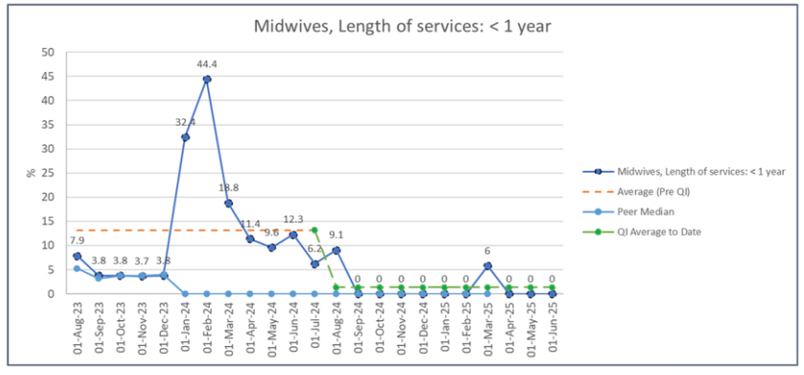
"I've noticed a massive difference now there is a preceptorship lead. I feel much more supported and know what I need to do to complete my preceptorship."

Key components of the implemented changes included:

- Appointment of a dedicated, supernumerary Lead Preceptorship Midwife
- Development and delivery of a structured, Trust wide preceptorship programme aligned with the National Preceptorship Framework
- 150 hours protected supernumerary time
- Named preceptor and buddy midwife allocation
- Bi-monthly one to one meetings
- Professional Midwifery Advocate access for pastoral support
- Education for senior midwives to build a supportive culture

Elements were assessed through self-reported experience (from the preceptees), quantitative measurements through leaver rates and assessed in quantitative themes from feedback received.

0-1yr Midwife Leaver Rates.



Watch Metrics Positive and Negative Results

Watch Metrics	Pre QI Intervention	Post QI Intervention
Satisfaction	21.1% Positive 68.5% Negative 10.5% Neutral	96.2% Positive 3.8% Negative
Support	26.4% Positive 73.7% Negative	100% Positive
Health and Wellbeing	0% Positive 94.5% Negative 5.6% Neutral	100% Positive
Competence	21.1% Positive 57.9% Negative 21.1% Neutral	100% Positive

Next steps and sustainability

- Following presentation of the project outcomes to the Trust Exec team, permanent funding for the Preceptorship Lead Midwife role was secured, and the role was successfully converted to a substantive position.
- Work will continue to build a longitudinal dataset to demonstrate long term impact on 0 to 5 year retention.
- Plans are in place to expand the early career midwife rotation model to offer broader clinical experiences and improve recruitment.
- Embedding civility, leadership development and psychological safety will remain ongoing cultural priorities.

MANAGE TOGETHER

Royal United Hospitals (RUH) Bath NHS Foundation Trust - Maternity System Training across Community Midwifery Teams and South Western Ambulance Service NHS Foundation Trust (SWASFT) Quality Improvement Project

Samantha Turner– Community Leadership Midwife & Project Lead
Katherine Jackson – Community Birth Lead Midwife
Jessica Murray – Quality and Education Lead Midwife
Victoria Medland – PROMPT Lead Consultant
Aimee Humphreys – Specialist Lead Midwife for SWAST & Community Midwife
Charley Robinson – Fetal Wellbeing Midwife and Maternity Practice Education Facilitator

Background:

Across all recent maternity inquiries, failures in teamwork, escalation, and cross-boundary working have been found to directly contribute to harm and enhanced realistic multidisciplinary training has been advocated.

We wanted to ensure that our maternity community emergency skills drills were collaborative with the ambulance service and tested the system



Aims and Objectives of the Project:

- To facilitate integrated maternity-system training delivered jointly across the community midwifery team and the ambulance service.
- Increase confidence and competence for all healthcare professionals in managing obstetric emergencies in out-of-hospital settings, in line with PROMPT principles

"When we usually encounter the ambulance team, it is in high stress (often emergency) situations, I feel it is important to run these drills when there is capacity to come together and calmly build up relationships and support educating each other in order to improve safety, care and outcomes for our mothers and babies"
Jess Murray Quality & Education Lead Midwife

"Failures to work collaboratively across disciplines results in poor outcomes"
Independent Maternity Review
Ockenden Report (2022)

Training Day Programme

Kit Drop	Everyone brings their kits, which allows us to compare and streamline what each person carries, and encourages discussion about what is required and the rationale behind it.
Drug Comparison	This exercise raises awareness of which drugs each team carries and encourages discussion about the most appropriate drug use in different situations.
3 Simulations - Learning-Led Drills	This exercise allows emergency drills to be practised in realistic community settings, providing not only clinical education but also an opportunity to test systems such as communication challenges (e.g., poor signal) and logistical barriers including stairs, limited space, and stretcher access.
Debrief & Policy Comparison	After each clinical skills drill, we spend around 45 minutes debriefing the scenario, discussing the learning points, and reflecting on what went well and what could be improved. The debrief also includes conversations about the most appropriate person to lead in each situation and a comparison of relevant policies.
Birthing out of Guidance Scenario	There has been a national increase in mothers birthing outside recommended guidance. This session explores the challenges health professionals face in these situations, along with the implications for professional accountability.

Proposed Benefits of the Quality Improvement Project:

- **Realistic context for decision-making:** Delivering training in real home environments ensures that the true conditions of a homebirth are considered, including limited space, lighting, equipment, and potential delays in accessing help.
- **Stronger multidisciplinary teamwork**: Training together helps build understanding of each other's roles, capabilities and limitations, and supports the development of a shared mental model for managing emergencies. This is especially important given the range of roles within the Ambulance Service, each with its own scope of practice and competencies.
- **Appropriate leadership**: Focused education on who is best placed to lead in different scenarios aims to support more efficient and effective management of real-life emergencies.
- **Testing system processes:** Realistic scenarios allow teams to identify areas for improvement in both equipment and wider system processes.
- **Reduced delays in escalation:** Joint training can help minimise delays that arise from uncertainty, hierarchy, or lack of clarity.
- **Improved communication under pressure**: Scenarios provide structured practice in clear, concise communication, including SBAR and closed-loop techniques.
- **Better understanding of escalation pathways:** Training clarifies when to call an ambulance, what information crews require, the support they can provide on scene, and how to coordinate an efficient transfer into hospital.
- **Enhanced confidence and competence**: Repeated exposure to emergency scenarios in community settings helps develop muscle memory for rare but critical events.
- **Alignment with national safety priorities:** The project directly supports recommendations related to teamwork, escalation, and cross-boundary learning.

Main Successes of Project:

- Improved processes for the efficient management of maternity and neonatal emergencies and safe transfer into hospital.
- Strengthened working relationships and improved collaboration between midwives and ambulance crews.
- 100% of attendees reported they would recommend the training day to others.
- 100% of attendees felt confident or extremely confident in managing emergency situations at home following the training.
- 87% of attendees rated each simulation as the most effective learning experience; the remaining participants rated the day as effective for learning.

Challenges of the project:

- Ambulance crew have no funded time to attend
- Release time for Midwives to attend

Lessons Learnt:

- There are different roles within the Ambulance Service and they can all have different skills and competencies.

Staff Feedback
"Incredibly helpful to have this run in a home setting, emphasised the practicalities that need to be considered that cannot be reproduced in a usual training room environment. Working alongside midwife colleagues was so helpful for shared learning and understanding. Almost certainly the most beneficial training experience I have had as a Paramedic"

Staff Feedback
"brilliant day, should be made mandatory."



Next Steps:

- To increase the number of sessions delivered and work towards making the training mandatory for all midwives.
- Explore funding options to enable ambulance crews to attend the training within paid hours.



"Dysfunctional teamworking within and across professional groups leads to suboptimal care"
Reading the signals: Maternity and neonatal services in East Kent. Bill Kirkup (2022)

Health Innovation West of England

NHS Gloucestershire Hospitals NHS Foundation Trust

Effective Perinatal Multi Disciplinary Team work for Improved Outcomes & Patient Experience
A Case Study Reflection – Asha Dhany –Midwife

Perinatal services sit at the intersection of high stakes, high pressured clinical environments, high emotion and high professional diversity, where midwifery philosophy, obstetric risk management and system pressures collide. Navigating this dynamic requires a culture that values psychological safety, mutual respect, and shared purpose.

When midwives and obstetricians move beyond professional boundaries to recognise the strengths of both physiological and medical models of care, the focus shifts from defending professional perspectives to collaboratively achieving the safest and most personalised outcomes for women and babies.

On a recent night shift, I took over the care of a woman expecting her 2nd and 3rd babies. It was a Dizygotic twin pregnancy with twin one being in the cephalic and twin two being in the breech position. The woman was term and had a previous normal vaginal birth. She was being augmented due to not going into spontaneous labour. During her pregnancy, the woman had been comprehensively counselled by her Consultant about her choices for birth and the risks and benefits of Caesarean section versus vaginal birth discussed. There was a detailed discussion documented in the woman's notes about the delivery of twin 2 being breech and the risks of vaginal breech birth. The woman had made her fully informed decision that she wanted to proceed with an induction and plan for a vaginal birth birth.

When I took over care, labour was just establishing from the small amount of Syntocinon that had been commenced a short while before. There was a lovely ambience in the room with dim lighting, the woman's choice of music and the gentle aroma of the aromatherapy she was using. The woman was calm and was being monitored effectively by a telemetry CTG. Maternal observations were all normal and both babies CTG traces were normal and reassuring. We quickly built up a pleasant and trusting relationship and chatted about birth preferences and what might happen between 1 and twin 2's birth and who and what equipment would be in the room. I answered any questions the woman had.

Labour progressed quickly and no concerns were identified. As labour became advanced the woman asked if she could adopt an all four/kneeling position on the bed. I supported her to get into her requested position but explained if we were unable to monitor either baby in that position we would have to change and that between twin 1 and twin 2 the Obstetrician would need to turn her around to be able to scan and stabilise twin 2. The woman was happy with this. Good contact was achieved on the CTG, and the woman found this position more comfortable. In this position, I was able to apply some back massage to support the woman with her increasing contractions as she rocked her hips from side to side. Not long after turning into all fours the woman started to give some involuntary pushes, and I observed a deep purple line in her anal cleft and rectal pressure and some anal dilatation. At this point I called the delivery suite coordinator to inform her that I felt delivery was imminent and ask her to inform the obstetric registrar on call.

Shortly after my call both the registrar and coordinator entered the room. The woman was continuing to contract regularly with increasingly expulsive spontaneous urges to push and increased rectal pressure and anal dilatation visible. On entering the room, the Obstetrician asked if I knew if the woman was definitely fully dilated, I replied I didn't know for definite but from my experience I was almost certain she was and that we would see a baby in the next few minutes. He suggested we got the mum over on her back and performed a vaginal examination to conclusively know. I knew the mother did not want this and I didn't feel it necessary at that point and asked as all was normal and reassuring if he could trust my experience and just give it a couple of minutes. I reassured the registrar that mum was happy to turn onto her back straight after the birth of twin 1 to allow him to perform an ultrasound and stabilisation of twin 2. He then suggested we turned mum on her back and catheterised her prior to birth,but again I reassured she had spontaneously voided in the last hour and asked if we could do this after she had birthed twin 1. Almost immediately after this conversation the vertex of twin 1 was visible and the woman quickly had a beautiful calm normal delivery of twin 1. She turned onto her back just after the birth to allow her to hold her baby skin to skin and for the Obstetrician to scan and stabilise twin 2. *(Continued on page 2)*

"Professional silos, tribal behaviours and failures of teamwork can become dangerous in healthcare".

Bill Kirkup

"The challenge in maternity care is not choosing between the midwifery model and the obstetric model but creating cultures where both forms of expertise are valued and integrated in the service of women and babies."

Midwifery & Obstetric Philosophies – How can we bring these philosophies and skills together to maximise patient experience and outcomes?

Midwifery Model	Obstetric Model
Birth is physiological	Birth is potentially pathological
Focus on normality	Focus on risk
Continuity and relationship	Episodic care
Minimal intervention	Preventative intervention

When the Obstetrician first entered the room and suggested vaginal examination and catheterisation as birth was imminent, I remember feeling some frustration and in the moment territorial and protective over the woman as well as my experience being questioned.

Remembering Midwives have often spent time with the woman and her family, building up a relationship and trust, listening to birth wishes and preferences, identifying their needs and preferred communication style and can support conversations in a way that the mother responds well to

Health Innovation West of England

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Effective Perinatal Multi Disciplinary Team work for Improved Outcomes & Patient Experience
A Case Study Reflection – Asha Dhany –Midwife

The Obstetrician identified on scan that twin 2 remained in the breech position. I sensed that the Obstetrician maybe felt anxious that Twin 2 remained breech and was perhaps feeling nervous about a physiological breech birth. Whilst I had not worked closely in a clinical context with this Obstetrician before, (prominently as my main role was as Practice Development Lead Midwife) we were familiar with each other from delivering training together. I reminded the Obstetrician I had spent the last year teaching physiological vaginal breech birth and was familiar with the manoeuvres and we could support each other. The delivery suite coordinator remained in the room and provided welcome calm reassurance and support to everyone in the room.

Over the next period of time after twin 2 was stabilised the woman's contractions were minimal. As we waited for contractions to build, reassured by the CTG trace, I subtly loaded up my visual physiological breech slides on the computer screen in the corner of the room. Me and the Obstetrician stood together familiarising and quietly talking through together the manoeuvres. This felt a lovely moment of flattened hierarchy where we both had our anxieties about how the delivery of twin 2 may go but had the time to familiarise and support each other and bring our knowledge and skills together and make a plan.

Despite the Syntocinon infusion contractions were minimal and we stood and waited for them to increase. I looked at the registrar and said how do you feel about me using my midwifery birth skills and doing some gentle aromatherapy massage with some clary sage and he looked at me and smiled and said 'of course'. I knew the woman would also welcome this and know we were trying our best.

As the contractions started to build the Obstetrician performed a vaginal examination to ascertain position and unfortunately could feel two little feet and the baby kneeling. We were all disappointed that it wasn't as straightforward as we hoped. The Obstetrician asked for my thoughts and asked if I wanted to check his examination. I really appreciated him inviting my thoughts and opinion, but I knew that this was beyond my experience and boundaries as a Midwife. I thanked him for asking but told him I respected and trusted his examination and decision making.

The CTG tracing remained normal and myself and the delivery suite coordinator remained in the room together supporting the woman whilst the registrar went and spoke to the Consultant on call (also the Consultant who counselled the woman regarding mode of birth and knew the woman well). The Consultant was very aware of the woman's strong hopes and wishes for a vaginal birth and to avoid Caesarean section. The options of attempting external cephalic version (ECV) or proceeding to theatre for Caesarean Section were given to the woman and she was really keen try an ECV The Obstetrician calmly and competently attempted to turn baby by ECV but unfortunately the attempts were unsuccessful. We all felt disappointment, particularly mum, but the decision was made to proceed to theatre for Caesarean section and mum reluctantly consented.

When we got into the theatre the Consultant on call had come into the unit to support the delivery. She discussed with the woman Caesarean Section versus a breech extraction and clearly verbalised the risks of breech extraction. The woman gave her strong preference and consent to the Consultant performing a breech extraction. The Consultant proceeded to perform a lovely successful breech extraction delivery of a beautiful healthy baby.

The elation and joy in the theatre from both the parents and us as staff was palpable as the mum got her birth wishes and after a prolonged duration between twin 1 and twin 2 both babies had safely arrived. I will never forget looking up at the registrar and us both smiling at each other!

This case has made me heavily reflect on the importance of bringing together midwifery and obstetric skills in a psychologically safe environment where there is flattened hierarchy. Ideas can be shared, constructively and kindly challenged, questions asked, and mistakes admitted without fear of humiliation, punishment or retribution, whilst remembering we are there with shared purpose wanting to achieve the same goal of safe and effective care.

'Modern medicine is a team sport, yet we often train and work as if it is an individual performance'.

Atul Gawande



Incivility between clinicians often stems from not knowing each other as people. It is important to create opportunities to get to know each other and build effective working relationships and trust for each other.

Optimal MDT Working

- Keeping the patient at the centre of the care
- Flattened Hierarchy
- Listening to each other's perspectives
- Respect for both physiological expertise and medical risk management
- Shared Decision Making

Collaboration requires respect across professional boundaries.

Listening and offering respect for each other's opinions.

Practical ways of Improving MDT Working

At MDT handovers or ward rounds – asking what are the midwifery skills and what are the obstetric skills we need here.

Debriefing as an MDT and listening to everyone's perspectives for future learning.

Ensuring MDT Training together and MDT case study discussions

Inviting Obstetricians to be observers on birth centres for low-risk birth and waterbirth

Having breaks together and promoting opportunities to get to know each other as people.

Maternity and Neonatal

From PROMPT to Practice: Building Safety Culture in the MOMENTS That Matter

Gill Travers, Registered Midwife Senior Project Manager, Health Innovation West of England

April 2026

NHS Gloucestershire Hospitals NHS Foundation Trust

in association with Health Innovation West of England



National maternity reviews and improvement programmes highlight that culture and leadership issues can contribute to avoidable harm and poor staff experience, including challenges with escalation, listening, and staff support following adverse events.

PSIRF expectations emphasise compassionate engagement and a learning-focused approach, using proportionate learning responses rather than defaulting to blame-oriented investigations.

Evidence underpinning MOMENTS demonstrates that structured participation in cultural conversations can improve openness, mutual understanding and the relational conditions needed for safer practice.

Maternity teams work in complex, high-pressure environments where safe care depends on strong teamwork, clear communication and psychological safety. Local learning from incidents and training can be undermined when staff do not have protected time to debrief, when hierarchy limits speaking up, or when safety activity becomes overly focused on compliance rather than the realities of day-to-day work. The specific prompt for action was the opportunity to use an established, well-attended PROMPT training day (including a shoulder dystocia station) as a safe environment to strengthen team culture and embed a consistent, system-focused approach to learning aligned with PSIRF principles.









Approach

Gloucestershire Hospitals NHS Foundation Trust integrated a facilitated MOMENTS conversation into a PROMPT multidisciplinary team (MDT) training day, using the shoulder dystocia station as a shared scenario for reflection. The discussion was deliberately aligned to PSIRF After Action Review questions to strengthen consistency with the Trust's wider approach to learning from patient safety events.

- Created protected time and space during PROMPT for MDT reflection on everyday practices and how team values are demonstrated in real work.
- Used MOMENTS to explore materials (tools/resources), competencies (skills/knowledge) and meanings (norms, hierarchy, expectations) that shape team performance.
- Made "work as imagined versus work as done" explicit, enabling staff to surface practical barriers (for example, equipment layout, role clarity, communication patterns, escalation thresholds).
- Supported the team to identify actions to start, stop or amplify, ensuring improvements were locally owned and feasible.
- Reinforced a just, fair and learning-oriented approach consistent with PSIRF, reducing fear of blame and supporting psychological safety.

Outcomes

Participants described the value of having a structured, neutral framework that enabled open discussion of concerns, emotions and practical barriers without personalising blame. The session supported connection after a demanding scenario, helping staff feel less isolated and more supported through shared reflection and mutual understanding.

By bringing a strengths-based, relational approach into routine learning, the work helped teams to focus on how they work together, how they communicate, and how values such as respect, compassion and civility are enacted during pressured moments.

Key Learning

- **Culture becomes tangible when explored through everyday practices** and the elements that shape them (materials, competencies and meanings).
- The process of engagement matters: **giving staff time and permission to reflect together builds relationships, trust and buy-in**, which increases the likelihood that improvements will be implemented.
- **Aligning culture conversations to PSIRF learning questions helps embed a consistent, fair and system-focused learning approach** across training and incident response.
- **Strengthening staff wellbeing and patient safety outcomes is inseparable from how teams relate, communicate and support one another** in everyday work.

Next steps and sustainability

- Continue MOMENTS-facilitated conversations alongside future PROMPT sessions to reinforce cultural norms and build continuity.
- Embed capture and tracking of improvement actions into existing governance and quality improvement structures, with clear ownership and review dates.
- Link learning to wider PSIRF learning responses (for example, SWARM huddles or MDT reviews) where themes emerge, ensuring a coherent learning system.

Perinatal Culture and Leadership Case Study – ‘From Acorn to Oak’

Organisation

Great Western Hospital NHS Foundation Trust in partnership with Health Innovation West of England (HIWE)

Completed by: Gill Travers, Registered Midwife and HIWE Senior Project Manager
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Title of case study: ‘From Acorn to Oak’ Does the implementation of a Lead Preceptorship Midwife and a structured preceptorship programme reduce the leaver rates of early career midwives; alongside improving their support, health & wellbeing, satisfaction and competence? Led by Kate Giles, RM

Summary

This case study outlines the implementation of a dedicated Lead Preceptorship Midwife and a structured preceptorship programme at the provider Trust. The aim was to address high early career midwife leaver rates, strengthen support systems, and improve Newly Qualified Midwife (NQM) confidence, competence and wellbeing. Within 10 months the 0 to 1 year leaver rate reduced from 13.8 percent to 1.3 percent and the Trust moved into the national top decile for 12 month rolling turnover. Significant increases were also seen across all wellbeing and support metrics. The intervention has delivered measurable cultural improvement and strengthened workforce sustainability.

What was the aim/problem?

The Trust faced significant workforce challenges, including:

- High turnover rates among early career midwives
- 70.2 percent of leavers in the previous 12 months were within their first 1 to 5 years
- A 12 month rolling turnover rate averaging 9.5 percent, consistently above peer benchmarks
- Reported stress, burnout and reduced confidence among NQMs
- No structured or standardised preceptorship programme in place
- No designated leadership for early career support

This created instability within the maternity workforce, negatively affecting morale, culture and safety.

What was the solution?

A Quality Improvement project was launched in September 2024 with funding accessed through NHS England.

Key components included:

- Appointment of a dedicated, supernumerary Lead Preceptorship Midwife
- Development and delivery of a structured, Trust wide preceptorship programme aligned with the National Preceptorship Framework
- Implementation of:
  - 150 hours protected supernumerary time
  - Named preceptors and buddy midwives
  - Bi-monthly one to one support meetings
  - A structured competency document
  - Regular access to Professional Midwifery Advocates
  - Education for senior midwives to promote supportive behaviours and cultural alignment
- Use of quantitative and qualitative data to measure impact, including:
  - Statistical Process Control (SPC) charting of leaver rates
  - Pre and post intervention questionnaires measuring satisfaction, support, wellbeing and competence

What were the challenges?

The main challenges were:

- Translating the concept of culture into practical, everyday behaviours
- Maintaining protected time for NQMs and preceptors during high acuity periods
- Embedding a new programme within an overstretched workforce
- Ensuring MDT wide understanding that preceptorship is a transition period, not immediate autonomy
- Temporary nature of national funding for the role affecting sustainability planning
- Balancing clinical demands with supernumerary leadership

What were the results: what was the outcome?

Quantitative results

0 to 1 year leaver rate:

- Reduced from **13.8 percent** to **1.3 percent**
- No NQMs left during the first seven months of the intervention period

12 month rolling turnover rate:

- Reduced from **9.5 percent** to **5.3 percent**
- Trust moved from above peer median to the **national top decile**

Watch metrics (self-reported experience)

All four metrics exceeded the 50 percent improvement target.

- Satisfaction increased by 75.1 percent

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- Support increased by 73.6 percent
- Health and wellbeing increased by 100 percent
- Competence increased by 78.9 percent

Qualitative themes

NQMs reported:

- Feeling significantly more supported both clinically and emotionally
- Improved sense of belonging
- Greater confidence and clarity in expectations
- Enhanced safety culture
- A belief that the role of the Lead Preceptorship Midwife was pivotal in their decision to stay

One participant reflected:

"If it weren't for the preceptorship lead being in post I do not think I would have stayed in midwifery."

What were the learning points?

A whole-team approach to culture change is essential, ensuring that support extends beyond the preceptor to the entire multidisciplinary team. Protecting time for learning is crucial for maintaining psychological safety and enabling meaningful development. While quantitative data provides strong evidence of progress, qualitative feedback offers important context by humanising the impact and deepening cultural understanding. Sustaining a positive culture also relies on leadership training and the promotion of civility. Clear communication and well-defined expectations help reduce anxiety during the transition period, creating a more supportive and stable environment for early career midwives.

Next steps and sustainability

- Following presentation of the project outcomes to the Trust Exec team, permanent funding for the Preceptorship Lead Midwife role was secured, and the role was successfully converted to a substantive position.
- Work will continue to build a longitudinal dataset to demonstrate long term impact on 0 to 5 year retention.
- Plans are in place to expand the early career midwife rotation model to offer broader clinical experiences and improve recruitment.
- Embedding civility, leadership development and psychological safety will remain ongoing cultural priorities.
- A mixed-methods approach will be adopted for future evaluation, incorporating ethnographic insights from NQMs.

Want to know more?

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Perinatal Culture and Leadership Case Study

Organisation

University of the West of England (UWE) in partnership with Health Innovation West of England (HIWE)

Completed by: Gill Travers, Registered Midwife and HIWE Senior Project Manager
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Title of case study: Embedding the MOMENTS Framework in Midwifery Education: Shaping Safety Culture through Everyday Practice

Summary

Through collaboration between the University of the West of England and Health Innovation West of England, the MOMENTS Framework was embedded into the Year 2 Pre-Registration Midwifery module. The session enabled student midwives to explore how everyday actions and shared values shape maternity safety culture. The collaboration supported the Perinatal Culture and Leadership Programme (PCLP) ambition to create compassionate, equitable, and learning-centred maternity environments. HIWE have been invited back to facilitate the session again with the next Year 2 cohorts in session that will be held in March 2026 and July 2026.

What was the aim/problem?

Maternity services in England have faced significant safety challenges, highlighted by reports such as *Ockenden* and *East Kent*. These identified that service users' voices were not heard, and staff felt unsupported. In response, NHS England's *Three-Year Delivery Plan for Maternity and Neonatal Services (2023)* called for a compassionate, learning-oriented culture shift.

At UWE, the opportunity was identified to prepare future midwives to lead that change in partnership with Health Innovation West of England. The aim was to embed cultural learning early in professional development by integrating the MOMENTS framework into the midwifery curriculum, connecting safety culture theory with quality improvement (QI) and leadership in practice.

What was the solution?

In October 2024, a new two-hour lecture with practical workshop elements was co-developed by HIWE the Health Innovation West of England Perinatal Culture and Leadership Programme workstream lead following a conversation with one of the University of the West

of England Midwifery lecturers. These sessions were facilitated for both of the Year 2 cohorts, with the first session taking place in March and the second being held in August 2025.

Drawing on the MOMENTS framework and QI methodology, the session enabled students to:

- Reflect on everyday practices (e.g. handovers, huddles, or making tea)
- Explore how values such as compassion, civility, and trust are enacted
- Understand the power of dialogue and shared decision-making in shaping culture
- Connect individual leadership behaviours with system-level improvement

Interactive exercises guided students through MOMENTS' social practice lens (competencies, meanings, and materials). The workshop mirrored PSC-led approaches to cultural improvement, encouraging curiosity, reflection, and psychological safety.

What were the challenges?

The main challenges were:

- Translating an abstract concept like "culture" into practical learning activities
- Ensuring relevance to students with limited clinical experience
- Balancing theoretical learning with the practical demands of a packed academic curriculum

Close collaboration between HIWE facilitators and UWE educators helped address these challenges, using relatable examples and embedding reflection as an assessed element of professional development.

Students described feeling empowered to act as advocates for women and families, and as contributors to improvement from early in their careers. They reported improved understanding of leadership roles, the importance of reflection, and how small actions can influence cultural change.

As a result of the PCLP, these student midwives are equipped to connect their daily practice with system-wide learning and improvement, strengthening the foundation for a positive safety culture in future maternity care.

What were the results: what was the outcome?

The session was well received, and qualitative feedback demonstrated strong engagement and learning impact.

Students described gaining:

- **A deeper understanding** of what contributes to positive safety culture
- **Confidence** to speak up and participate in cultural change

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- **Insight** into systems that support safe, compassionate maternity care

Selected feedback quotes:

“What was useful for me in this session was gaining a deeper understanding of what contributes to a positive safety culture, especially through a strengths-based approach that focuses on what is working well rather than solely on errors or incidents.”

“This session allowed me to gain an understanding of the systems available and the process behind MOMENTS conversations in maternity care… and how I can contribute to cultural improvements.”

“The MOMENTS tool was useful and I feel better educated on QI plans and why they’re important. This was the most useful session of the day.”

“It was helpful to understand and break down social practices and how competencies, meanings, and materials shape everyday practice.”

“The session was incredibly insightful… the main takeaway for me is to not be afraid to speak up!”

These responses show the MOMENTS framework’s potential to influence individual confidence, systems thinking, and advocacy for patient voice.

What were the learning points?

- Embedding cultural learning in education helps bridge the gap between theory and practice.
- Focusing on everyday social practices makes “culture” visible and discussable.
- Creating psychological safety in learning environments encourages openness and critical reflection.
- Using MOMENTS as a framework enables structured, compassionate conversations about safety, voice, and improvement.

Next steps and sustainability

UWE and HIWE plan to continue the MOMENTS session within the Year 2 midwifery curriculum, with a possible option to explore its application in other health professional programmes. The collaboration will continue to support the PCLP’s national goals through shared learning and faculty development.

Want to know more?

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Perinatal Culture and Leadership Programme 2025-26

Logic Model – Alignment with Maternity Incentive Scheme Year 7

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Context

Alignment of existing reporting for the Maternity Incentive Scheme (MIS) Year 7 with the Perinatal Culture and Leadership Programme (PCLP) will support organisations to participate in improvement work without increasing burden of capacity in teams; it will support organisations in evidencing their MIS submissions and strengthen practices becoming embedded by forming part of the evidence portfolio moving forward. This logic model illustrates how PCLP activities align with and support the achievement of MIS Year 7 safety actions, using an input-output-outcome-impact framework.

Aims

- Improve the quality of care and experiences of women, babies and families by enabling leaders to drive change with a better understanding of the relationship between compassionate and inclusive leadership, safety improvement and safety culture.
- Support perinatal leadership teams to create and craft the conditions for a positive culture of safety and continuous improvement, enabling a more psychologically safe, collaborative, and supportive workplace.
- To embed culture work in everyday practice.

Inputs

- Culture Coaches (trained and supported)
- MOMENTS Framework
- Quad Teams (local perinatal leaders)
- QI Coaching and Support
- Culture Conversations Infrastructure
- Learning Networks/Systems
- Equality, Diversity and Inclusion (EDI) expertise

Activities

- Facilitate cultural conversations across perinatal services
- Support Quad teams with leadership development and improvement planning
- Provide targeted QI coaching to embed cultural improvements
- Train and sustain Culture Coaches as culture change agents
- Embed MOMENTS to reflect on and improve safety culture
- Host learning events to share best practices
- Promote alignment with EDI and other NHSE initiatives

Outputs

- Cultural improvement plans in every Trust
- Ongoing engagement between Quad teams and staff
- MOMENTS sessions across clinical teams
- EDI-aware safety culture interventions
- Regional learning systems with cross-site collaboration
- Resources and case studies uploaded to national platforms

Short-Term Outcomes

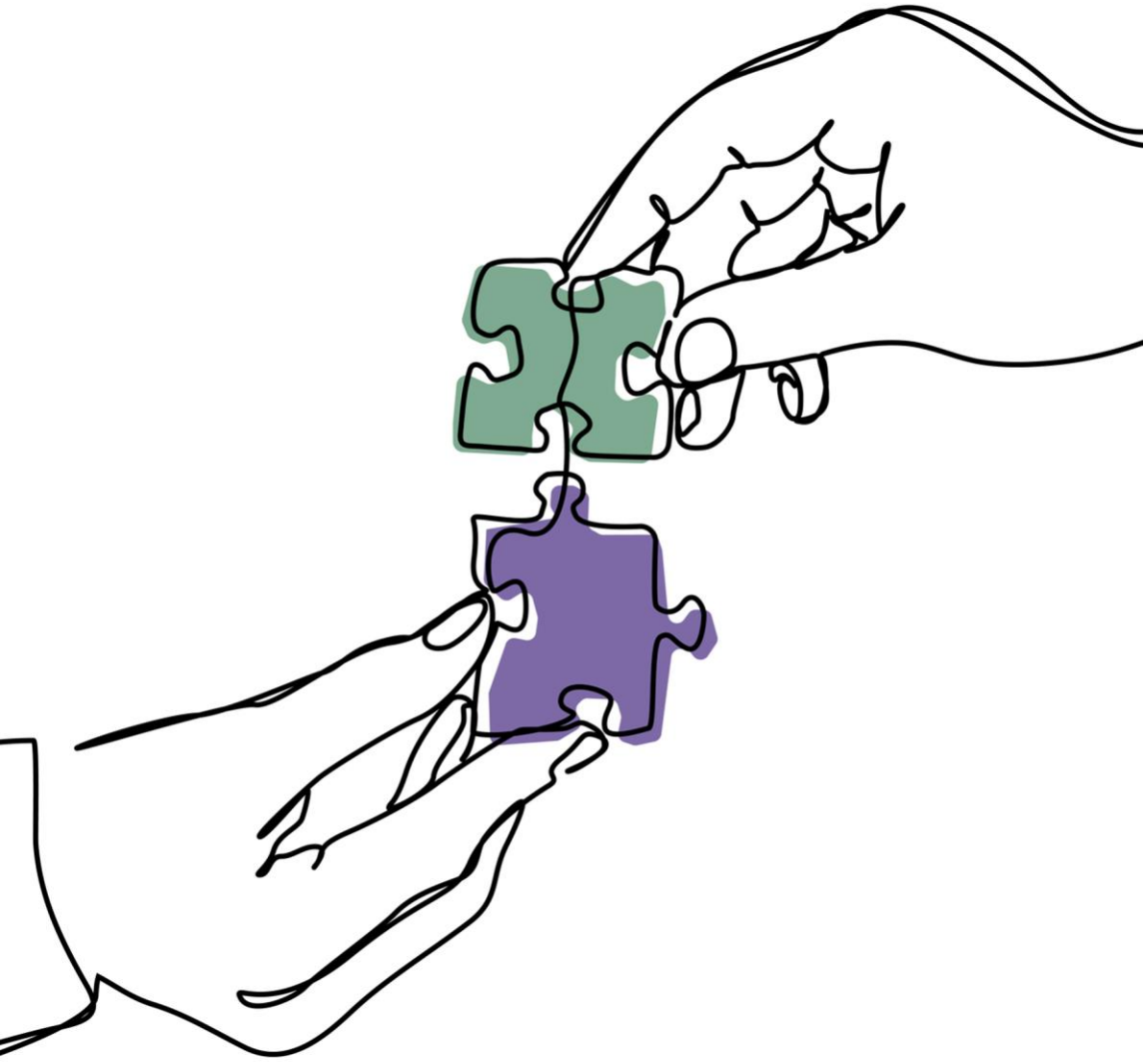
- Greater psychological safety and openness in perinatal services
- More inclusive staff engagement in safety efforts
- Increased data quality, training participation, and staff retention
- Transparent and timely reporting to MNSI and NHSR EN scheme
- Improved quality and oversight of maternity care at Board level

Long-Term Impact

- Trusts meet or exceed all ten MIS Year 7 Safety Actions
- Enhanced culture of safety and learning embedded in everyday practice
- Measurable reduction in avoidable harm in maternity and neonatal care
- Sustainable leadership structures supporting continuous improvement
- Culturally competent, inclusive and compassionate care delivery

Perinatal Culture and Leadership Programme 2025-26

Key Enablers Provided by PCLP



- MOMENTS Framework
  - Helps measure and reflect on safety culture.
- Culture Coaches
  - Facilitate staff engagement and feedback loops.
- Quad/ Perinatal Leadership Teams
  - Drive leadership accountability and cultural change.
- Learning Systems
  - Enable cross-site learning and showcasing.
- EDI Integration
  - Ensures inclusive approaches underpin cultural work.

Perinatal Culture and Leadership Programme Alignment with Maternity Incentive Scheme Year 7

To align the PCLP Specification Deliverables (2025–2026) with the Maternity Incentive Scheme (MIS) Year 7 Safety Actions, we have mapped to demonstrate how the PCLP deliverables correspond to or support each of the ten MIS safety actions.

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MIS Safety Action	PCLP Alignment
1: Use of PMRT for perinatal death review	• PCLP encourages cultural conversations and psychological safety, which can improve openness and accuracy in reviews like PMRT. • Culture Coaches facilitate trust-building which supports effective PMRT discussions and family engagement.
2: Submission to Maternity Services Data Set (MSDS)	• While not directly focused on data, PCLP's improvement culture indirectly supports better data collection by promoting accountability and communication across teams.
3: Transitional care and reducing separation	• MOMENTS and cultural improvement work can reduce mother-baby separation by improving multidisciplinary collaboration and care planning. • Engagement in cultural work may enhance pathway development and implementation.
4 & 5: Clinical and midwifery workforce planning	• Focus on compassionate leadership and sustainable change supports workforce morale and retention. • Culture Coaches and Quad teams promote understanding of safe staffing needs and escalate challenges constructively.
6: Compliance with Saving Babies' Lives Care Bundle (SBLCB v3)	• PCLP learning systems and MOMENTS support local improvement against SBLCB by encouraging reflection on care quality and actionable insights.
7: Co-production with women, parents, and families	• Culture Coaches and MOMENTS explicitly promote engagement with diverse voices, including marginalised and minoritised groups. • Supports the creation of inclusive, user-informed action plans following feedback like the CQC survey.
8: Multi-professional training	• Cultural support improves team dynamics and willingness to engage in multidisciplinary learning. • MOMENTS can be embedded within training to foster reflective practice.
9: Board oversight and safety intelligence	• PCLP fosters meaningful engagement between Board-level leaders and frontline teams through regular updates, learning systems, and feedback loops. • Emphasis on culture improves use and impact of tools like PQSM and PSIRF.
10: Reporting to MNSI and EN Scheme	• Encouragement of openness, psychological safety, and duty of candour through cultural conversations supports accurate and timely reporting. • MOMENTS can assist teams in recognizing and documenting qualifying incidents effectively.

PCLP 2025-26 and MIS Yr 7 Alignment Matrix

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MIS Safety Action	Description	Aligned PCLP Deliverables	Notes for Board / LMNS Reporting
1	Use of PMRT to review perinatal deaths	Cultural conversations, psychological safety, Culture Coaches, MOMENTS	Encourages open dialogue, thorough reviews, and family engagement. Supports staff to feel safe sharing insights during PMRT panels.
2	Submission to MSDS	Culture of accountability, engagement support	While indirect, improved team culture enhances data completeness and accuracy.
3	Transitional care and QI to reduce separation	MOMENTS, QI coaching, inclusive teamwork culture	Supports development and implementation of TC pathways through reflective practice and system collaboration.
4	Clinical workforce planning (obstetric, anaesthetic, neonatal)	Quad team leadership development, coaching support, MOMENTS	Leadership development supports sustainable staffing and clear responsibilities. Reinforces role clarity and rest provisions.
5	Midwifery workforce planning	Compassionate leadership, psychological safety, cultural engagement	Enhances team understanding of staffing needs, supports safe supernumerary roles and one-to-one care culture.
6	Compliance with Saving Babies' Lives v3	Learning systems, MOMENTS, coaching for QI plans	Fosters regular, reflective practice. MOMENTS supports discussion of clinical improvements.
7	Coproduction with families and MNVP action plans	Culture Coaches, inclusive engagement, EDI focus	Builds infrastructure for coproduction and responsiveness to user feedback (e.g., CQC Survey).
8	Multi-professional training compliance	MOMENTS integration, culture of learning, team safety focus	Enhances participation and retention in training through improved team cohesion and psychological safety.
9	Board oversight and use of safety intelligence	Learning systems, PQSM alignment, culture reports to Board	Facilitates robust Board discussions with cultural context, integrates PSIRF, and showcases learning outcomes.
10	MNSI & EN scheme reporting + family comms	Cultural conversations, duty of candour focus, psychological safety	Supports transparent, compassionate reporting and communication with families. Aligns with Regulation 20 duties.

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Maternity (Perinatal) Incentive Scheme (MIS) Year 8

A Summary of Changes and Alignment with Health Innovation Maternity and Neonatal Safety Improvement Programmes

01 April 2026

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MIS Year 8: Why the changes and what's new

Year 8 is a refreshed and streamlined MIS model, shaped directly by Trust feedback and the MIS evaluation, to:

- Clarify purpose and outcomes so requirements feel meaningful and impact-focused.
- Increase local flexibility by reducing prescription and supporting Trusts to evidence "what good looks like" in their context.
- Reduce process burden and duplication, focusing effort on the areas most likely to improve safety, quality and culture.
- Strengthen governance and assurance by improving clarity on Board accountability and expectations for robust, locally held evidence.

New structure: Six core safety actions and a clearer format

The scheme has introduced six core safety actions (A–F), reorganised by theme and intention, supported by supplementary guidance and examples.

Each safety action now follows a consistent structure to support outcome-focused implementation and Board assurance:

- **Outcome:** the change expected when requirements are implemented.
- **Why:** the purpose behind the requirement, linking it to safety, quality and culture improvements and what should happen when themes, delays or risks are identified.
- **What:** a concise, high-level map of the minimum mandatory elements for compliance, without prescribing one operational approach, enabling Trusts to determine how to meet requirements locally and assure their Board accordingly.

Transitioning to an Outcome-Focused Safety Action Structure



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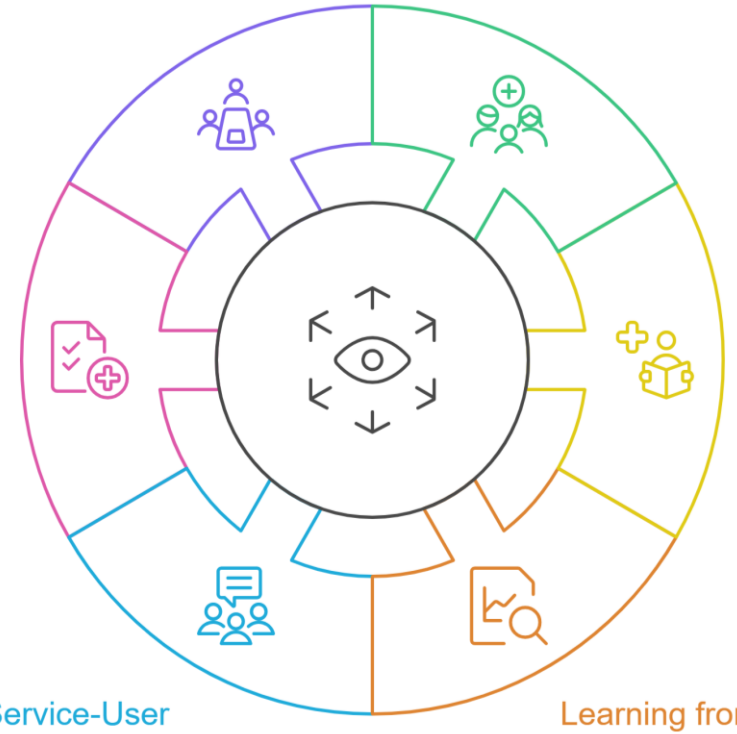
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Board Oversight

Visible Board oversight, MOSS use, culture plan.

Workforce and Capacity

Ensure adequate staffing and resources for safe care.



Care Bundles

SBLCB progress, MCB plan, universal pulse-ox.

Training

Multi-professional training, supporting competence and sustained compliance.

Service-User Voice

Co-produce improvements, address inequities, improve access.

Learning from Reviews

Triangulate learning, involve families, track impact.

MIS Year 8 streamlines the scheme from ten actions to six core, outcomes-focused safety actions:

A - Workforce and capacity,
B - Training,
C - Learning from reviews and investigations,
D - Service-user voice and equity,
E - Care bundles,
F - Board oversight, governance, culture and leadership.

The scheme is more principles-based and emphasises local outcome delivery over process compliance.

Year 8 is being used as a bridging year, as the model has changed - with a sample mid-year check-in with randomly sampled Trusts.

The new standards were developed with a wide group of stakeholders, including Royal Colleges, national Perinatal groups/bodies, regulatory and safety organisations and service user representatives.

The documents were further refined through engagement with a wide range of provider Trusts and their Perinatal leadership teams.

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Summary of Changes by Safety Action

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A - Workforce and Capacity

- Year 8 combines all maternity and neonatal workforce requirements into one multi-professional action.
- Sets clearer expectations for consultant presence, anaesthetic cover, neonatal staffing and locum use.
- Removes supernumerary coordinator and 1:1 labour care from MIS, but services should still monitor via red-flags.
- Adds operational capacity monitoring, including elective Caesarean activity via SitRep.
- Continues funded midwifery establishment (BirthRate+) and funded neonatal establishment requirements.
- Confirms need for trained anaesthetic assistants and progress towards peri-operative team models.

B - Training

- Year 8 strengthens training and assurance with two compliance checkpoints (30 Nov plus one local).
- Training continues to cover fetal monitoring, maternity emergencies and neonatal resuscitation.
- In-situ simulation now required in both hospital and community settings.
- Anaesthetic training requirement reduced to a half-day to support attendance.
- Impacted Fetal Head (IFH) scenarios must be included by year end to align with Avoiding Brain Injury in Childbirth (ABC) preparation.

C - Learning from Reviews and Investigations

- Year 8 strengthens triangulation of reviews with wider safety intelligence, ensuring early identification of themes and meaningful family involvement.
- Includes the Perinatal Mortality Review Tool (PMRT), MNSI and Early Notification (EN) learning now aligned, with Submit a Perinatal Event Notification (SPEN) as the single national notification route.
- PMRT external review threshold increased to 60%.
- Quarterly Board-level thematic reports required.
- Greater focus on learning → action → impact.
- Statutory Duty of Candour reporting removed from MIS (already a legal requirement).

D - Service-user Voice and Equity

- Strengthened focus on communication equity, ensuring women and families can understand their care and participate fully with appropriate language support and reasonable adjustments.
- Service-user-led improvement, using lived experience to identify priorities and barriers to safe, respectful care.
- Emphasis on equity, using local data to identify groups with poorer access or outcomes and addressing identified gaps.
- Maternal and Neonatal Voices Partnership (MNVP) guidance issued by NHS England still applies. However, recognising capacity is sometimes limited, it is no longer a requirement for MIS. Where capacity is limited, trusts must ensure diverse and representative service user voices inform priorities, improvement work and governance.

E - Care Bundles

- Year 8 introduces a more targeted local approach to Saving Babies' Lives Care Bundle (SBLCB) alongside preparation for the new Maternity Care Bundle (MCB).
- Quarterly SBLCBv3.2 reports required at Trust Board, reflecting local progress, implementation, incidents and safety intelligence.
- ICB assurance step removed as ICBs no longer hold a formal oversight role.
- Trusts must develop an MCB implementation plan with quarterly Board oversight.

F - Board Oversight, Governance, Culture and Leadership

- Clearer expectations for Board-level assurance and use of safety intelligence.
- Routine use of the Maternity Outcomes Signal System (MOSS) and associated SOPs.
- Bimonthly Board Safety Champion meetings with MNVP involvement.
- Live Perinatal Culture Improvement Plan required, with quarterly Board review.

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Alignment with Health Innovation MatNeoSIP Programmes

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MIS Year 8 Safety Action	What's Required?	Aligned MatNeoSIP programme deliverables	How engaging in the programmes can support MIS Year 8
A. Workforce and capacity	Board oversight of MDT workforce and capacity planning across maternity & neonatal teams; monitoring and escalation of persistent capacity issues (incl. planned CS pathway capacity mapping).	**MEWS/NEWTT2** implementation readiness explicitly requires multi-professional leadership and organisational readiness (incl. stakeholder groups and readiness work across leadership, staff readiness, governance, measurement, resources) to support safe deterioration response.	Use MatNeoSIP readiness activity to support evidence of role clarity, leadership structure, and workforce impact assessment for deterioration pathways (e.g., who responds, who escalates, how handover works). This strengthens the MIS A narrative (though staffing standards still need local workforce evidence).
B. Training	Board oversight of MDT training/competency (obstetric emergencies, fetal monitoring, neonatal resuscitation, in-situ simulation—hospital + community), with compliance checkpoints and reporting.	**MEWS and NEWTT2** require staff readiness and training planning, including improvement support where there are known issues with compliance/escalation/response. **ABC** requires cascaded training (faculty → T2 trust/site leads → T1 staff) and fidelity to approach; MIS B also explicitly expects IFH scenario inclusion by year end to align with ABC preparation.	Support evidence MIS B through: (1) MEWS/NEWTT2 training plan + staff trained counts; (2) case studies showing escalation behaviours improved (PIER); (3) ABC readiness—IFH scenario incorporated into MDT emergency training and/or simulation schedule; (4) board-ready training compliance trajectory with narrative on escalation practice.
C. Learning from reviews and investigations	Quarterly thematic learning reports triangulating national/local intelligence; "learning → action → impact"; parent involvement and robust governance.	MatNeoSIP expects measurement and local evaluation of MEWS/NEWTT2 implementation (e.g., compliance audits, staff trained, time to escalation case studies) within PIER. ABC includes feedback mechanisms ("share and learn"), phased implementation, and reporting routes, supporting systematic learning capture.	Fold MatNeoSIP/ABC reporting into MIS C quarterly thematic reports: include deterioration themes (missed recognition, delayed escalation, response delays), actions taken (training, pathway redesign), and evidence of impact (audit trends/case reviews). Use programme "share & learn" outputs as appendices or supporting evidence.
D. Service-user voice and equity	Service-user voice drives improvement; communication equity (language support/reasonable adjustments); use demographic insight to address inequities.	NEWTT2 escalation explicitly includes parent worry/concern and aims to improve parent/family experience within escalation pathways. MatNeoSIP expected outcomes include improved experience via engagement with women/families regarding escalating concern; triage scoping aims to reduce variation and improve triage systems.	Evidence MIS D by linking programme work to: (1) how women/families raise concerns in triage/postnatal/newborn settings and how staff respond; (2) co-designed patient information for escalation routes; (3) triage baselining that highlights equity gaps and improvement actions. Supplement with local interpreting/reasonable adjustment evidence as MIS D requires.
E. Care bundles	Board oversight of SBLCBv3.2 progress, plan for Maternal Care Bundle by March 2027, and neonatal pulse oximetry guideline including escalation pathways.	MatNeoSIP is not a care bundle programme, but it strengthens the escalation infrastructure (PIER, MEWS/NEWTT2) and measurement approaches that can be reused in bundle oversight reporting.	Use MatNeoSIP to evidence the "how" behind bundle safety: consistent escalation behaviours, reliable response pathways, and measurement discipline. For pulse oximetry, explicitly align escalation steps with PIER principles and newborn deterioration response culture supported by NEWTT2.
F. Board oversight, governance, culture and leadership	Board receives comprehensive maternity/neonatal safety intelligence; escalation routes; safety champions; MOSS critical safety checks/drills; culture improvement plan.	**MEWS/NEWTT2** implementation support includes explicit focus on guidelines/governance alignment, measurement, resources, and addressing escalation/response culture; also requires stakeholder and network engagement to sustain implementation. **ABC** includes defined support offer, reporting expectations, phased milestones, and escalation of barriers—all of which support board assurance.	Evidence MIS F by integrating MatNeoSIP/ABC governance into board cadence: adoption/spread narrative (MEWS/NEWTT2), readiness status, training progress, escalation culture risks, and barrier escalation. Use programme milestones and measurement plans as board assurance artefacts that show "active grip."

ABC – MOMENTS Worksheet

CTG Escalation

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- Fetal monitoring knowledge and training
- Awareness of when to escalate/red flags
- Correct categorisation of CTG – understand the interpretation and categorisation system/guidelines in use
- Understanding of the escalation pathway
- Understanding of setting up patient details on the CTG system
- Knowledge of physiological changes in labour that may impact fetal wellbeing as part of the holistic assessment
- Ability to read the CTG trace —whether this be paper based or electronic
- Situational awareness
- Pattern recognition to detect change over time
- Challenges in evidence-based practice vs. available guidance

- Understanding your own scope of practice
- Recognising when a fetus is not responding to initial measures
- Communication skills
- Medicines competency (IV's, terbutaline, prescribing processes/midwives exemption)
- Understanding of digital systems(including centralised monitoring)
- Risk assessment i.e. why is the CTG in use?
- Human factors understanding (AID/ CUSS/ PACE)
- Confidence to escalate/jump escalate
- Fetal auscultation competency
- Informed consent



- Unit/team culture - Skills mix
- Call bell use/call bell fatigue
- Guidance in use (NICE versus physiology guidance and the challenges of how this may impact your confidence/ competence when working across a region)
- Reliance on Senior Midwife/Band 7 providing escalation to Obstetric SpR/Consultant
- History – personal experience both in clinical outcomes and escalation/communication/trauma response
- "physiological/ normal birth" ideology
- Litigation concerns *"if it's not written down it didn't happen"*
- *"historical"* blame culture vs. just and fair culture
- Medicalisation and interventions
- National policy and frameworks which increase interventions to "reduce" morbidity and mortality rates
- Not wanting to feel like a burden to the team during high periods of acuity
- Team dynamics – is this a well developed, cohesive team or are the relationships new and developing?
- Confirmation bias - Racial bias - Conscious/unconscious bias

- Handheld Doppler - Pinnard stethoscope
- CTG Review tool (sticker/BadgerNet)
- SBAR - Escalation pathway
- CTG machine - Belts/straps - Transducers
- CTG paper - Fetal monitoring guideline
- FSE - ?Fetal blood sampling (FBS)
- MDT Team available
- Access to an ambulance/theatre
- Phone – mobile with signal and emergency call system
- Call bell - Pen - Clock/watch
- Centralised Monitoring (Wi-Fi/ethernet)
- Contact gel - Terbutaline

ABC – MOMENTS Worksheet

Perinatal Deterioration

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- Competency and skills required to perform observations – maternal/neonatal/both (role dependent)
- Recognition of normal/abnormal parameters
- Understanding the need for appropriately sized equipment
- Updated information relating to observation charts – digital skills, where implemented within electronic patient record systems (BadgerNet etc.)
- Record keeping management – paper charts/ uploading to digital records
- Escalation pathways – in place
- Appropriate procedures to support Bank/ Agency staff to understand changes in pathways and processes
- Communication skills – consent, sharing of observations and what they mean, 'soft signs'

- Understanding of system biases within technology – i.e., racial bias for pulse oximeters
- Understanding of maintenance requirements and schedule and recognising when these need to be carried out – how to perform checks on local equipment
- Guidance/ Policies/ Standard Operating Procedures – understanding and interpreting documents and when escalation is required for different circumstances
- Recognising the impact of pain presenting through abnormal observations
  - Holistic assessment of needs/ situation/ circumstances



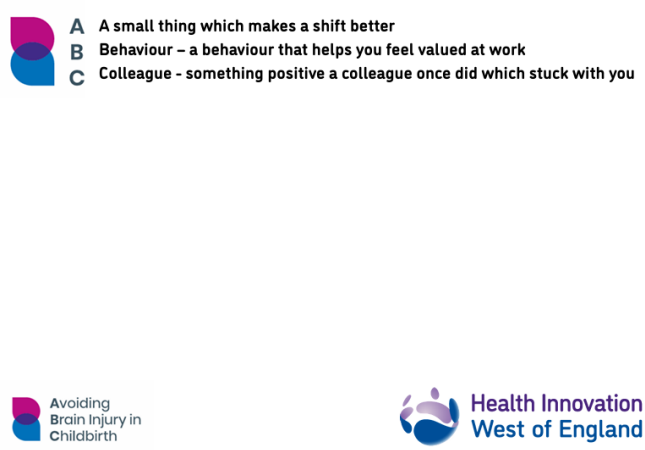
- Accessibility requirements/ troubleshooting as required i.e., not taking a temp in the ear of a hearing aid
- Professional curiosity/ experience/ '*sixth sense*' to appreciate the recorded observations whilst feeling confident to escalate if it feels '*off*'
- Exclusivity of handovers/ do not disturb during shift change which can delay escalation
- Recognising when fatigue is impacting clinical judgement and referring appropriately to another practitioner
- Local decision to respond to 'personalised' observations rather than the parameters within guidance, i.e., what is 'normal' for that person and therefore when does escalation need to happen
- Confirmation bias / situational bias
- *'White coat syndrome'* and how this may impact observations

- SBAR - Escalation pathway
- MDT Team available - Personalised care plan
- Enough staff to accommodate regular observations
- Access to an ambulance/theatre
- Phone – mobile with signal and emergency call system
- Call bell - Pen - Clock/watch
- Log-in to digital system/ appropriate recording device (handheld/ iPad/ laptop) - Agency/Bank log-ins
- Digital monitors – Sphygmomanometer (BP cuff) in regular and large sizes, pulse oximeter, thermometer with associated single use covers/ Clinell wipes
- Bin - PPE - Private examination space
- Access to a sluice/dirty utility
- Translation app/system
- In-date PAT testing of electronic equipment/ or within the maintenance schedule

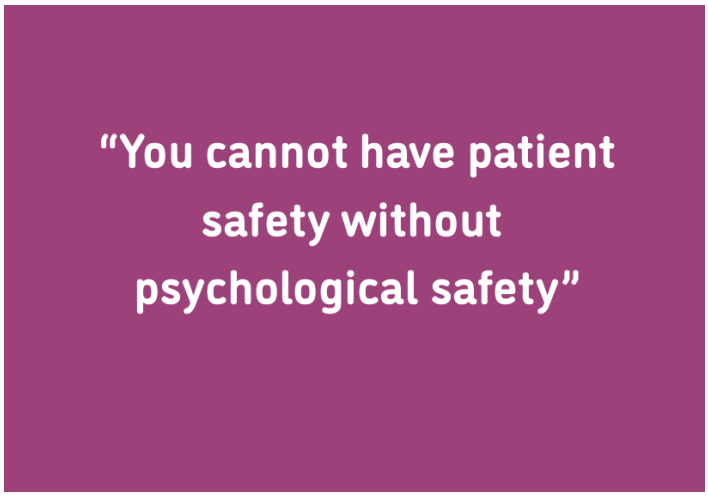
Culture Postcard Icebreaker Activity

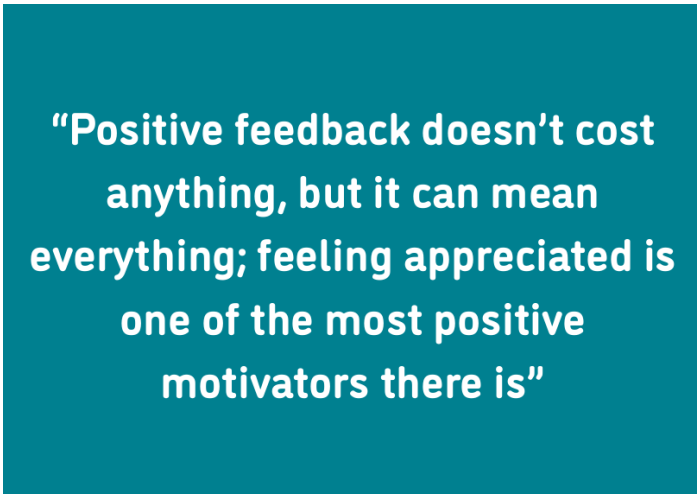
5 Designs of postcards were created to get attendees at our ABC launch event to think about culture, kindness and civility. A full selection of these postcards were spread out across the tables at our event and in the icebreaker activities attendees were encouraged to share their thoughts in an A,B,C format shown below. These insights have been collated and posters and training slides developed with information collected regarding what small thing makes a shift better, what behaviour makes you valued at work and something a colleague once did which study with you.

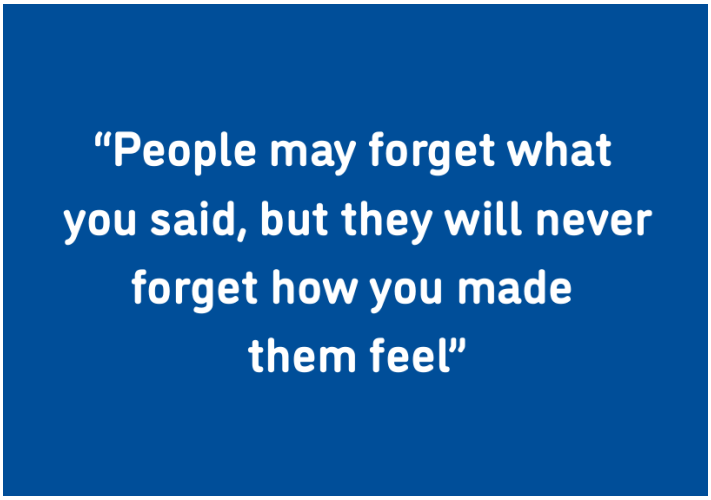












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Cultural Ice Breaker Exercise Insights from Avoiding Brain Injuries in Childbirth Impacted Fetal Head Launch Day



A A small thing which makes a shift better
B Behaviour – a behaviour that helps you feel valued at work
C Colleague - something positive a colleague once did which stuck with you

"People may forget what you said, but they will never forget how you made them feel"

"Positive feedback doesn't cost anything, but it can mean everything; feeling appreciated is one of the most positive motivators there is"

"Small acts of kindness create safe spaces and when staff feel safe, patients are safer"

"You cannot have patient safety without psychological safety"

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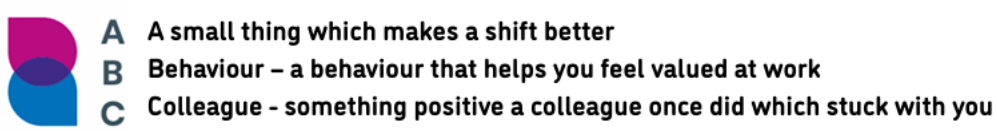
"Culture is built in everyday moments, and a positive safety culture is essential in improving patient outcomes"



A A small thing which makes a shift better
B Behaviour – a behaviour that helps you feel valued at work
C Colleague - something positive a colleague once did which stuck with you

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When we ran our Avoiding Brain Injuries in Childbirth (ABC) Impacted Fetal Head (IFD) Launch Day we started the day off with a positive cultural conversations and insights activity. Several postcards with positive cultural quotes were laid out on the tables and attendees were asked to share:



The following slides are the collated insights from this exercise.
Organisations were given packs of these postcards to use with their own teams on training days. We found that the exercise generated a really positive start to the day. Please feel free to use these following slides on training days to share insights as to what makes a shift better, helps people feel valued at work and positive colleague interactions. They can also be printed as posters to put up in areas if you feel this would generate positive in your workplace.

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A small thing which makes a shift better

Kindness

Positive Outlook and positive attitudes of staff

A Great Team

Enough & working Equipment

Checking in, Listening & Support

Eye Contact

A Break

Happy Vibes

Coffee & Cake!

Sharing Personal Lives

Positive & Approachable Shift/Team Leader

Someone Making you a Cup of Tea

Recognition amongst colleagues

Feeling Valued and Respected

Giving & Receiving Praise

Smiles, Jokes and Laughter

People saying Hello

A small thing which makes a shift better
B Behaviour – a behaviour that helps you feel valued at work
C Colleague - something positive a colleague once did which stuck with you

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A behaviour that helps you feel valued at work

Recognition of a tough shift

Someone listening and engaging with ideas and being enthusiastic about change

Shift Lead thanking you and ensuring everyone has gone home or is ready to go home

Positivity

People offering you help

Kindness & Gratitude

Collaboration

People noticing and thanking each other for their hard work

Receiving thank you by any means

Someone making you a drink or offering you a snack

Being asked for advice/your opinion as part of MDT

A small thing which makes a shift better
B Behaviour – a behaviour that helps you feel valued at work
C Colleague - something positive a colleague once did which stuck with you

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Something positive a colleague once did which stuck with you

A colleague recognising when I had dealt with a difficult situation and came and brought me chocolate and let me debrief



People checking in with you before, during and after a shift as appropriate





It's the small things that count



Small acts of kindness

Being sent a Greatix!



The Team Lead supporting the whole team & being inclusive

Hello and recognition when you arrive at work

Someone turning up to help without being asked



Being sent an email of thanks for my work

Acknowledgement



Being personally thanked

Shift Lead bringing me a drink



A small thing which makes a shift better
B Behaviour – a behaviour that helps you feel valued at work
C Colleague - something positive a colleague once did which stuck with you