Trauma-Informed Maternity Services Pathfinders – Learning Report

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Responding to Psychological Trauma in Scotland

Trauma-Informed Maternity Services Pathfinders – Learning Report

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Executive Summary

Background

Commissioned as part of the National Trauma Transformation Programme (NTTP), the Scottish Government funded four pathfinder projects with a focus on two priority sectors: maternity and substance use services. This report presents a summary of learning from the two maternity pathfinders which were based in Forth Valley and Grampian Maternity Services. The pathfinders took place over a 15-month period from January 2022 to March 2023.

The learning report is intended to support services across Scotland to consider the opportunities and challenges of planning for, developing and implementing sustainable trauma-informed (TI) practice. A key aim of the pathfinders was to enable all staff working in maternity and neonatal services to be TI and appropriately responsive to women, individuals and families who have lived or living experience of trauma (LLET).

Approach

The pathfinder areas were provided with dedicated support from a specialist in midwifery and TI Practice, as well as support from a monitoring and evaluation specialist. The maternity pathfinders followed three key phases:

1. Understanding service context and readiness for TI Practice;
2. Improvement planning, informed by phase 1 learning;
3. Implementation of agreed priority areas.

Key Learning

The priority areas of transformational change within both maternity pathfinder areas were identifed as:

- Workforce development;
- Workforce wellbeing;
- Screening and documentation of disclosed trauma.

Identified activities within the pathfinders Theory of Change plan (ToC) required further detailed planning to support implementation through development of topic specific driver diagrams, logic models and measurement plans for each of the three areas. This recognised the vast transformation process required within the ToC plan and broke this down into meaningful and realistic activities. In recognition of the limited knowledge and experience in Quality Improvement (QI) within each pathfinder board, the specialist maternity TI lead and evaluation expert facilitated several in-person events to develop pathfinder teams' understanding of QI and the implementation journey, supported with the NHS Education For Scotland (NES) QI resources.

Workforce Development

The Scottish Trauma Informed Leaders Training programme (STILT) supported leaders from the Maternity Trauma Informed Steering Group (MTISG) through access to action learning workshops and ongoing, implementation support from the Improvement Service and/or local Transforming Psychologial Trauma Implementation Co-ordinator's (TPTICs) as well as through links with Trauma Champions.

The workforce Training Needs Assessment and NTTP training plan resource guided the level of training required across the maternity and neonatal core workforce, identifying a requirement for all staff to have training at a 'skilled level'. Some practioners were noted to have more enhanced contact with families with LLET within their area of speciality such as Perinatal Mental Health, early pregnancy, public protection or substance use, requiring further assessment on their training needs.

The training programme has been developed from the six 'skilled-level' modules produced by the NTTP. Four e-learning modules that support the understanding of the impact of trauma and how to develop a trauma informed approach, and two e-learning modules focusing on promoting worker well-being and psychological first aid. These combine learning activities that develop understanding on requirements to become TI, as well as building the important conditions through developing their own wellbeing and principles of implementation science. In recognition of maternity interventions increasing the potential risk of re-traumatisation, the recently updated 'One out of four' E-module is also included. Evaluation of the programme's impact has seen a clear postive shift in the workers' confidence across all the key components of the learning. Higher positive levels of change were particlarly noted around psychological first aid, understanding the window of tolerance, producing their own wellbeing plans and the impact of trauma on mental health.

Workforce Wellbeing

Nationally reported NHS workforce pressures, recruitment and retention of staff and their impact on both the organisations' and workforce wellbeing was evident within both maternity pathfinders. This highlighted the need for an initial focus of pathfinder support to be targeted towards the 'Workforce wellbeing' driver. The MTISG produced a driver diagram, logic model and change ideas that aimed to support staff wellbeing. Identified secondary drivers included:

- A process to monitor and evaluate staff psychological wellbeing across the workforce;
- Supervision provision that enhances staff support and wellbeing;
- Effective and easily accessible workforce wellbeing initiatives;
- A formalised process of staff support following a traumatic event, reducing the risk of secondary trauma;
- Coaching process throughout service improvement to become TI;
- Policy/ guidelines that enhance wellbeing through the TI Principles.

Workforce drop-in sessions were established in the pathfinder areas. These provided an effective process to allow the key workers to have a voice on the most appropriate form of support, barriers and to identify new initiatives. This allowed the development and implementation of more accessible and effective interventions. Organisational challenges, culture and leadership have been highlighed as barriers to the workforce feeling able to access appropriate supports when required.

Identification of key staff members with a role to support their staff or colleagues and have the knowledge and experience to provide a range of supervision supports, is fundamental within the development of a sub-group to lead on workforce wellbeing change. Within maternity settings, the pathfinder learning has suggested a need for a review and redesign of a more efficent, supportive provision which encompasses clinical supervison, reflective practice, coaching and peer support components.

Embedding the current NES wellbeing modules within training plans fosters staff engagement and provides new workforce wellbeing supports and understanding.

Screening and Documentation of Disclosed Trauma

Within the timescale of the pathfinders, the MTISG have reviewed learning from the voices of those with Lived and Living Experience of Trauma (LLET). This included developing their understanding of implementing the TI principles, and the production of a driver diagram, logic model and change ideas. This aimed to ensure:

'All pregnant women residing in their geographical board, who have experienced/ or are experiencing trauma are identified and supported to develop trauma-informed and person-centred maternity plans of care'.

Recognition that midwives have a digital platform with embedded practice that aligns with 'Getting It Right for Every Child' (GIRFEC) and 'Child Protection' processes that involve screening for some previous traumas, the primary drivers include:

A maternity and neonatal services workforce that has the appropriate knowledge and skills to recognise, respond to and record women's experience of trauma which require:

- Review of the current process on screening and documentation of previous or recurring trauma;
- Workforce trained in NTTP skilled level, maternity and neonatal training and trauma; screening, recording and care plan development;
- Collaboration across departments, professions and specialist roles;
- Consistent approach across the local authority care provision;
- Alignment of trauma screening with GIRFEC and child protection practice.

Families with a history of trauma, attending the maternity and neonatal service help inform screening, documentation and care planning which require:

- Collaboration with families with lived experience of trauma to develop a standardised tool/ process for screening;
- Guidance on how disclosed trauma is recorded;
- An agreed trauma-informed and person-centred plan of care.

The identification of key representatives to develop a focus group to lead on this work included specialist roles supporting families with high incidence of trauma, community midwifery, maternity digital leads, maternity clinical psychologists (MNPI) and 3rd sector supports such as Maternity Partnership Voice. These representatives are identifed as key roles that can identify and connect families they are supporting to participate in the development of guidance on screening, documentation and care plan development.

The limited timeline of the pathfinder support has not allowed progress of this area of work to-date but this has been recognised as a priority area over the coming year. It is anticipated that this priority area will entail a great deal of commitment, collaboration and resource but is an essential area of transition. Recognition and collaboration across national 'Routine Enquiry' activity is essential in progressing this priority.

Conclusion

Nationally reported NHS workforce pressures, recruitment and retention of staff, and their impact on both the organisation and workforce wellbeing was evident within both maternity pathfinders, directing an initial focus of pathfinder support to be targeted towards the ‘workforce wellbeing’ driver with associated support activities. This provided a platform that initiated conversation, considered early change ideas embracing TI principles, while developing more accessible and effective workforce wellbeing initiatives.

Development of an implementation steering group, with representation across services and departments recognised to support families across their pregnancy, who will lead project planning, implementation and evaluation, is essential in supporting an enhanced and consistent multi-agency TIP and culture.

Existing NTTP e-learning modules and implementation supporting resources were transferrable to the maternity setting, supporting the pathfinders to develop a Maternity and Neonatal Trauma Skilled Training Programme and helping to inform improvement planning. Embedding reflective practice and coaching sessions provided the opportunity to consider, plan and implement new learning into practice, with evidence of early activity occurring.

Activities that collaborate with LLET are essential in informing implementation planning with feedback loops. pathfinder familiarisation activity identified many existing processes, from services within and who work alongside maternity services, that provide reflection on experience from families accessing the service that required connection to better inform changes required in the wider service.

It is recognised that due to the ongoing development of an NTTP Roadmap that there will be a need to update learning and align it with updated/additional drivers. The maternity pathfinders will be encouraged to assess their progress against the Roadmap when launched. Future focus will include a deeper understanding in relation to; leadership, culture, powersharing with those with LLET and routine enquiry of trauma.

Summary Report

Background

Commissioned as part of the National Trauma Transformation Programme (NTTP), the Scottish Government funded four pathfinder projects with a focus on two priority sectors: maternity services and substance use services. This summary report presents learning from the two maternity pathfinders which were based in Forth Valley and Grampian Maternity Services. The pathfinders took place over a 15-month period from January 2022 to March 2023.

This learning report is intended to support services across Scotland to consider the opportunities and challenges of planning for, developing and implementing sustainable trauma-informed (TI) practice. A key aim of the pathfinders was to enable all staff working in maternity and neonatal services to be TI and appropriately responsive to women, individuals and families who have lived or living experience of trauma (LLET). The learning from the pathfinders has also informed the development of a forthcoming NTTP Roadmap for Trauma-Informed organisations, systems and workforces.

Context

The Scottish Government's ambition, shared with COSLA, is for a trauma-Informed and responsive workforce and services across Scotland. This ambition is supported by the National Trauma Transformation Programme[1] founded on Transforming Psychological Trauma: A knowledge and Skills Framework[2] (2017), developed by NHS Education for Scotland (NES).

Being 'trauma-informed' means being able to recognise when someone may be affected by trauma, collaboratively adjusting ways of working to take this into account and responding in a way that supports recovery, does no harm and recognises and supports people's resilience[i]. Being TI involves:

- **R**ealising how common experiences of trauma, adversity and ACEs are
- **R**ecognising the different ways that trauma can affect people
- **R**esponding to support recovery
- **R**esisting re-traumatisation
- Recognising the central importance of **R**elationships
- Respect **R**esilience

Trauma-informed approaches will benefit all people who come into contact with members of the workforce, including people with experiences of trauma and Adverse Childhood Experiences (ACEs) and/or people impacted by socio-economic disadvantage and discrimination, as well as all others.

Five key principles underlie trauma-informed practice: **safety, trust, choice, collaboration**, and **empowerment**. The development of trauma-informed practice requires systems, services and organisations to be aligned with these five principles. Therefore, implementation of trauma-informed practice is often described as an 'ongoing process of change' or a 'continuum of implementation'.

Being 'trauma-informed' is not about providing interventions for trauma-related difficulties, although that can be part of it in certain contexts. It is about enabling members of the workforce to address the barriers that people affected by trauma can experience when accessing the care, support and

[1] https://www.transformingpsychologicaltrauma.scot
[2] https://transformingpsychologicaltrauma.scot/about-the-programme/transforming-psychological-trauma-a-knowledge-skills-framework-2017/

treatment they require. It also involes preventing trauma related distress that can be triggered by any contact with staff in services (i.e. re-traumatising).

The importance of involving people with LLET and adversity is essential in developing trauma-informed approaches. It is also acknowledged that members of the workforce will likely be affected by trauma, through their own personal experience and, in many cases, 'vicariously' in the course of their work. It is particularly challenging for staff to support people affected by trauma when their own wellbeing is at risk. Workforce wellbeing is therefore fundamental to a trauma-informed approach.

Learning highlights that workforce training is a key component of any organisation's journey to becoming trauma informed. Equally important are the culture, environments, and supportive ways of working in an organisation that can enable sustainable change that makes a difference to all of us who are affected by trauma. No matter how trauma-informed a practitioner may be, if we are constrained by protocols or policies that do not recognise the impact of trauma, we may be unable to minimise the risk of re-traumatisation that our training has taught us to recognise. This can risk disempowering staff and creating a sense of helplessness, leading to potential disengagement from empathy for people we are supporting.

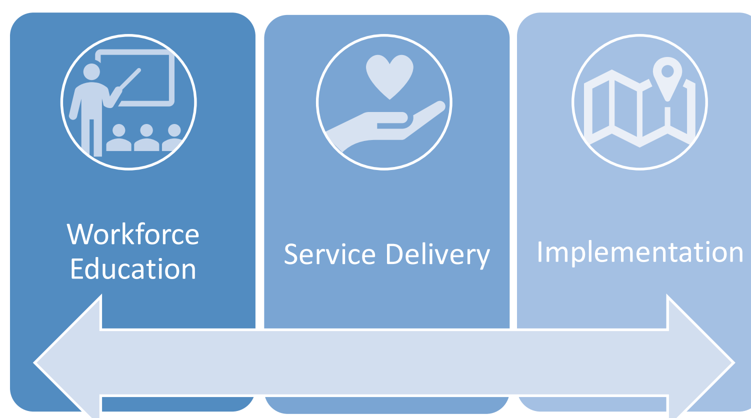
Transforming Psychological Trauma in Maternity Services: Nursing, Midwifery and Allied Health Professionals (NMAHP)[3] Project Report

As part of background scoping, NES comissioned research exploring the views of maternity care staff in Scotland. This focussed on the workforce knowledge, skills and identified barriers and enablers to develop trauma-iInformed maternity services. Common themes were found across all professional groups highlighting clear knowledge and confidence gaps and a desire to learn and respond more effectively to the psychological trauma experiences of women, birthing people and their families.

There was further recognition that all staff working within or alongside maternity and neonatal services have a key role in ensuring women, individuals and their families feel safe and secure during their pregnancy journey and that the transition into parenthood is important. The project identified the necessity for substantial scoping of workforce development needs relating to trauma-informed care provision for maternity and neonatal services.

[3] https://learn.nes.nhs.scot/60198/women-children-young-people-and-families/2021-maternity-services-report-transforming-psychologica

The report concluded with recommendations based on three overarching themes to help facilitate the next steps in leading Scotland's maternity services towards becoming truly trauma responsive. If actioned these recommendations will ensure that women/individuals have a positive experience in their pregnancy and parenting journey, while diminishing the longer term negative impact of past adverse or traumatic experiences. The recommended three themes from NMHAP Project report are:



A key recommendation was to identify two maternity pathfinder project boards to explore what tangible steps are required to design, deliver, and sustain Trauma Informed maternity services. This was supported by the Scottish Government NTTP Steering Group and led to the Maternity Pathfinder Project.

Approach to Pathfinders

The pathfinder areas were each provided with dedicated support from a specialist in Midwifery and Trauma-Informed Practice (TIP), as well as support from a Monitoring and Evaluation specialist. The pathfinders followed three key phases:

1) Understanding service context and readiness for TI Practice.
2) Improvement planning, informed by phase 1 learning.
3) Implementation of agreed priority areas.
4)

Pathfinder Methods and Timeline

Phase 1: Understanding service context and readiness for Trauma-Informed Practice (January 2022 – June 2022)

Familiarisation with the current service provision and relationship building through:

- Supporting key stakeholders to develop a shared understanding of the aims and objectives of the pathfinder project and gaining leadership commitment from the onset;
- Establishing a Maternity Trauma Informed Implementation Steering Group (MTISG);
- Familiarisation and multi-agency scoping sessions to understand; the current systems and services, the key workforce/partners involved, existing TI knowledge and practice, and how feedback from experts by experience are currently gathered;
- Trauma Informed Lens Event in collaboration with those with LLET;
- One to one sessions to hear the voice of those with LLET;
- Workforce training needs analysis (TNA);
- Collaboration with local Trauma Champions and Transforming Psychological Trauma Implementation Co-ordinators (TPTIC).

Phase 2: Improvement Planning Informed by Phase 1 Learning (June 2022 – March 23)

Based on the learning outcomes from Phase 1, Phase 2 included:

- Organisational self-assessment and improvement planning using NTTP resources and draft Maternity Service Improvement planning tools- 'Creating trauma- informed change in maternity services: Implementation guidance and planning resource'[4] and 'Implementation guidance for trauma- informed care in Scotland: A tailored organisational self-assessment resource for maternity services') [5];
- Developing a Theory of Change (ToC) model agreeing priority areas, associated activities with embedded monitoring and evaluation structures.

Phase 3: Implementation of Agreed Priority Areas (Nov 2022 – March 2023)

- Access to Scottish Trauma Informed Leaders Training (STILT).
- Review findings from the Training Needs Analysis to inform workforce development planning.
- Development and delivery of a Maternity Tailored Skilled level Trauma Training Programme that embeds reflective practice and coaching structures, to support implementation of new learning.
- Support for workforce health and wellbeing initiatives implementation planning.
- Screening, documentation and care plan implementation planning.

[4] 'Creating trauma informed change in maternity services: Implementation guidance and planning resource' was tailored from previous guidance developed for the older adult settings writing by A. Homes and commissioned through the NTTP (publication forthcoming)

[5] 'Implementation guidance for trauma informed care in Scotland: A tailored self-assessment resource for Maternity services' - was tailored for Maternity services from https://www.gov.scot/publications/trauma-informed-practice-toolkit-scotland/

1. Phase One: Understanding Service Context and Readiness (See Appendix A -Road Map)

Understanding the organisation or service context and readiness for transformation to become TI is a vitally important step that takes time. Without having an indepth understanding on their current position and their organisational readiness, which is inclusive across the workforce of the Integrated Joint Boards (IJB), implementation plans may become ineffective. A key lesson from the maternity pathfinders familiarisation sessions, was that there were key aspects of the NTTP themes/ drivers that leadership were not always aware of and some disconnect between embedding of new initiatives with workforce engagement or uptake. This summary report follows the pathfinder journey as directed by the maternity services readiness and capacity.

1.1 Leadership: Strategic and Operational

When progressing Trauma Informed Practice (TIP), early connection with key stakeholders across each pathfinder IJB is essential. This requires both a strategic and operational level of leadership which is essential to facilitate a shared understanding of project components and to obtain commitment and ownership from the onset. Engagement should be inclusive of all services/ agencies involved in caring for families throughout pregnancy and the initial postnatal period. Identification of a senior maternity member as the main project contact with responsibilty to feedback progress and learning from the pathfinder activity to senior stakeholders within their board is also vital.

This early communication recognised the vast array of professionals that families meet, services they engage with and connections they make in their pregnancy. This, in turn, allowed identification of key representatives who were invited to their local Introduction to the pathfinder meeting. The meetings were held at both a strategic and operational leadership level and facilitated early collaboration with local area Transforming Psychological Trauma Implementation Co-ordinators (TPTIC) and Trauma Champions. TPTICs and Champions are based in each board area and provide trauma expertise to organisations to support, raise awareness and influence action including training, coaching, implementation and collaborations with people with lived experience of trauma.

1.2 Familiarisation and Multi-Professional Scoping Sessions

Responding to the recognition that familes are supported by a range of professionals across departments and services (both within and working collaboratively with maternity services), it is important that scoping is not restricted to core maternity staff. It is essential to understand current systems, service provision, collaboration with key partners, existing TI knowledge and practice, and how feedback from those with LLET are currently gathered across sectors.

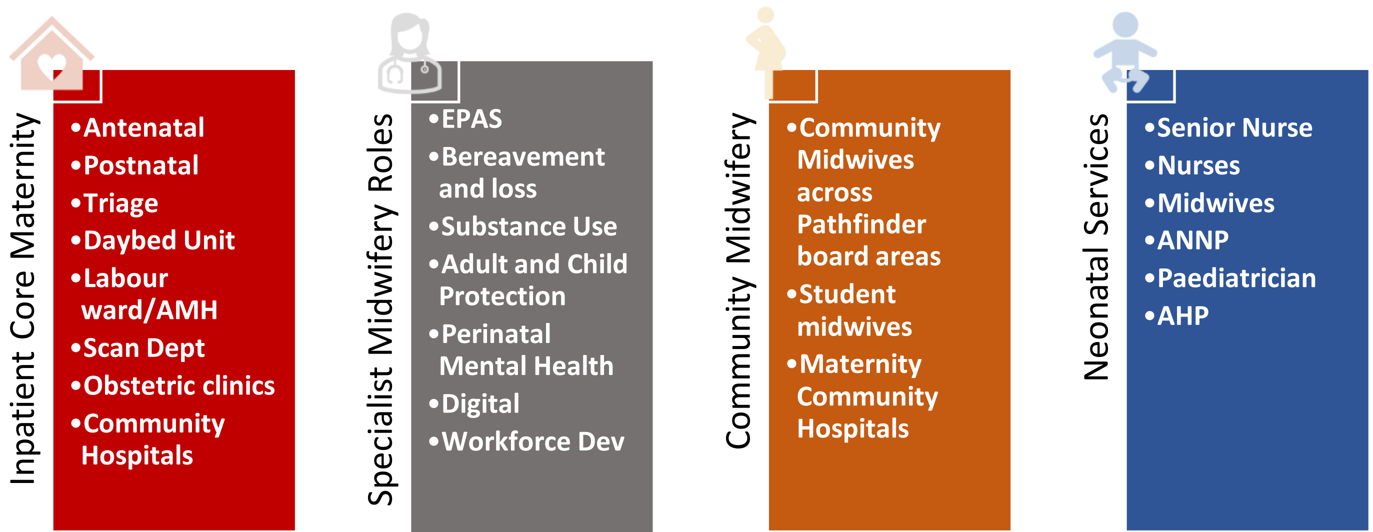
Learning from Multi-Professional Scoping Sessions recognised that maternity care provision often crosses several local authority areas in both rural and urban settings, with varying processes and service provisions, which may impact TIP. Technology and interfaces were found to be complex, with a range of different systems used that did not communicate with one another and increased thepossibilty of those with LLET retelling their story and increasing the risk of re-traumatisation. New specialist service developments were identifed with challenges in sourcing appropriate locations to provide TI care effectively. Construction of a new hospital in one board area is in progress, highlighting the time and efforts needed for planning and transitions of services and how this will impact their capacity to progressing TIP.

All services reported significant workforce challenges with high absence rates, recruitment and retention difficulties and loss of experienced staff impacting skill mix needs in their service provision. As a result, workforce wellbeing was reported to be impacted negatively despite acknowledgement of key support initiatives embedded during the COVID pandemic. In addition, there was inconsistency or absences evident in supervision, reflective practice and supports across different professional groupings/settings (despite many supporting the same families). If these were consistently provided and of high standard they would reduce the impact of vicarious trauma across agencies and roles.

Limited knowledge, or access to NTTP training was evident across agencies. Those within specialist roles, who worked with families with LLET, reported a better understanding of identifiying and supporting families in a TI way. However, key components such as TI principles or drivers to become TI were often unknown. Social work representatives in leadership positions reported involvement and awareness of IJB pre-existing trauma training and joint TI steering groups within their board.

Family Nurse Partnership (FNP) representatives discussed their training and programme of care provided, which embeds and is driven by TI principles and drivers. Their professional supervision structure was identified as being 'Gold Standard' in supporting workforce health and wellbeing and reducing the impact of vicarious trauma on their teams. Health visitors and some community midwives highlighted Child Protection supervision from local Child Protection advisors was effective and supportive when required.

The multi-professional scoping sessions were grouped into the following:



Multi-agency sessions considered the following key components:

Checklist

- Role, responsibilities and length service
- Service team and skill mix
- Service base, provision and target audience
- Multi-agency working and processes
- Screening and documentation of trauma
- Understanding of NTTP and Providing TIC
- Trauma training accessed or accessibility
- Workforce health and wellbeing policy and iniatives
- Identified TIP, enablers and barriers
- Processes to hear voice of LLET
- Management support
- Policies, guidelines, processes and service priority drivers

1.3 Maternity Trauma Informed Implementation Steering Group (MTISG)

Within larger organistions, such as maternity services, establishment of a multi-agency implementation steering group is essential from the onset. Membership should include those recognised as key professionals who will lead on developing and implementation of service change with partners in the transition to become a TI maternity service. The MTISG should embrace learning from the pathfinder familiarisation and scoping activities to inform their local ToC model. Within smaller services, development of actions plans may be sufficient.

Early project planning, leadership introductions and familiarisation sessions across the pathfinder board, helped identify key stakeholders involved in providing care to families across their pregnancy journey. In establishing the MTISG representation was sought from; midwives (across departments and roles), obstetricians, neonatal nurses/advanced neonatal nurse practictioners (ANNP), paediatricians, allied health professionals (AHP) (sonographers, occupational therapists),

anaesthetist, perinatal and infant mental health (PIMH), Maternity and Neonatal Psychological Interventions (MNPI), social services, addiction services, health visiting / family nurse and third sector organisations. In addition, engagement and involvement of local TPTICs and trauma champions was crucial in guiding local joint implementation board direction and learning.

The MTISG developed locally agreed 'Terms of Reference' and aimed to convene monthly meetings through a combination of Microsoft Teams and in-person sessions. Members have been encouraged to access STILT training and embrace support from their local TPTIC. Implementation resources, developed and adapted as part of the pathfinder specific to maternity and neonatal services, have supported the members to evaluate their position in delivery of TIP and guide development of key change ideas.

There were difficulties in securing attendance across representatives due to existing workforce challenges and competing agendas. This has impacted the continuity of representation, the progress of the agreed group activities and difficulties in forward planning in the absence of key individuals.

1.4 Trauma Informed Lens Event

The NTTP have developed a resource[6] for services to use to support them to consider their own organisation service provision using the key trauma principles of safety, choice, collaboration, empowerment and trust. This resource provides step by step guidance, directing participants to apply the TI Lens tool to their setting to support identification of:

- **Areas of good practice** – Keep and do more of;
- **Identified risk of retraumatising** – Stop or change;
- **Recognised opportunities** – add into their service.

A journey for families, from confirmation of pregnancy until transfer of care in the post natal period, consists of attendance at a variety of appointments within different departments and services. Reflection on these journeys highlighted the range of professionals involved, processes and interventions of a sensitive nature encountered, and the impact this may have on those with LLET.

The Trauma Lens Tool, 'Workshop Guidance Notes'[6], programme was extended to a full day, to allow the development of department / team specific maps of care and collaboration with families with LLET, who had recently received maternity care. Participants from the core workforce were identified through the MTISG and attendees were split into sub groups to review their service journey. Specific sub group settings were:

- Inpatient setting
- Community Setting
- Midwifery / Obstetric Specialist Support
- Triage / Interm care
- Neonatal setting
- PMH and MNPI
- Health Visitors
- Scan Department

The participants considered the prevalance of trauma, recognising the impact and how they respond to those they are supporting within their service via facilitated discussions in their groups. They recognised common trauma events they support included: birth related trauma, bereavement/ loss and recurrent miscarriages, gender based violence, ACE's, sexual trauma, physical assault or a significant trauma incident such as road traffic accident or episodes of significant ill health. They identified that the definition and impact of a traumatic event can vary person to person.

[6] https://learn.nes.nhs.scot/44605/national-trauma-training-programme/taking-a-trauma-informed-lens

Each group used the TI principles to consider every contact or experience women with LLET may have within their department. The groups were able to use their findings to develop 'Plans for Trauma Informed Change' specific to their area of work, which supported their local implementation team to develop their ToC model and guided activities. Common themes across services included:

Keep and Do More Off	Add into service or practice	Stop or Change
• Continuity carer or Team • Holistic assessment • GIRFEC Screening • Person centred care plans • Informed choice • Multi-agency communication/ working • Collaborative Birth Plans • Risk assessment and planning • Embedded pathways • Orientations for staff and families • Specialist Support Teams • Initial 'Debrief'for staff	• TI Training for staff • Protected time and resource • Extend time for appointments • Client Informed 'Trauma Section' in Badgernet • 'Safe Space' for staff and families • Revisit risk assessment and plans in collaboration • Embed process for meaningful client feedback • Multi-agency accessible info • Prioritise care vs department activity • Accessible Information for families • Enhance wellbeing supports • Improve communication across dept, agencies and care timeline	• Use of negative language • Reduce amount of care providers women see • Multiple appointments for families with complex needs – consider 'One Stop Shop' • Inconsistent systems, digital platforms and equipment • Ineffective handover of care • Staff support following adverse events – enhance • Cultural attitudes – presumption and impact on care

A pdf of this image is available separately on request if a larger font size is needed.

The sessions concluded with smaller facilitated discussions with women who were recognised to have experienced a traumatic event, to reflect on their unique, care journey, highlighting:

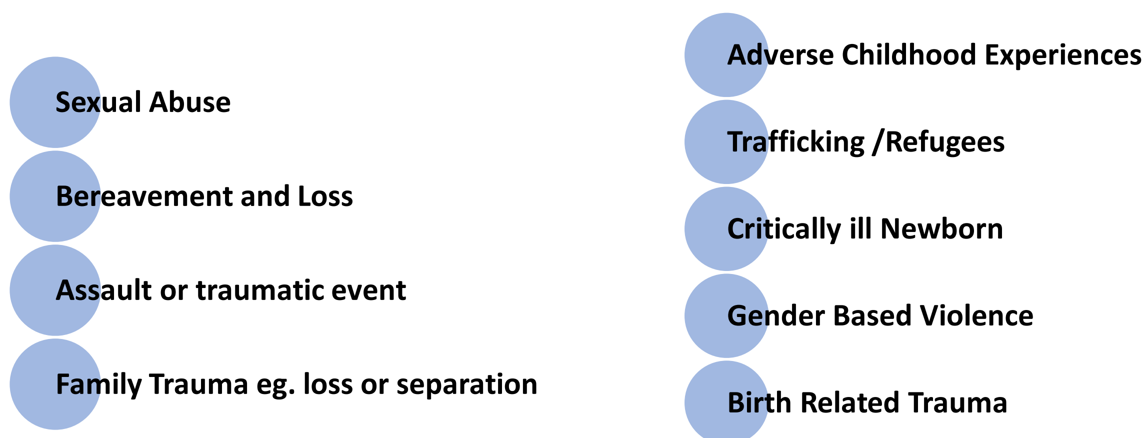
- areas they felt to be good practice and supportive;
- areas of difficulties/ challenges they faced;
- areas recognised to be a risk of re-traumatising;
- suggested areas of improvement to better the care for families attending maternity services.

1.5 Voice of Those with Lived and Living Experience of Trauma (LLET)

We cannot expect to develop TI maternity services and systems if we do not listen to and learn from people who have experienced trauma to understand what changes need to be made within the services we provide. Leaders, experts by profession and experts by experience all bring different knowledge and expertise about what works and what doesn't when supporting people to recover from trauma. Power sharing collaboratively, developing processes so that people affected by trauma are safely and meaningfully involved in decision making leads to developing services that are more likely to be designed around people's needs. This can help reduce barriers for people to access support, ensure those services and systems are seen as supportive resources for people affected by trauma, and ultimately contribute to improved outcomes for people and

communities. No service or system can be trauma-informed if it is not informed by people with lived experience of trauma.

Families were identified who had recently received care from the pathfinder service, had a history of trauma and were comfortable to share their experience through one-to-one interviews with the Project Leads. The families were identified through maternity and neonatal staff with a specialist role (Public Protection, Substance use, FNP, MNPI, Bereavement, PMHT) and local 3rd sector organisations. These organisations provided emotional support for the women to share their experience within a confidential and psychologically safe environment. All details shared remained anonymous and were collated to present to the pathfinder MTISG and Senior Midwives. Early scoping and workforce recognition of traumas from the 'Trauma Informed Lens Event' identified traumas commonly seen within maternity services included women who experienced:



Feedback was informed by women's unique experiences and varied depending on the event(s) which led to their trauma. Learning relating to service provision and care, which impacted on trauma, was fed back to the local service leads. Key learning from across LLET interviews highlighted common themes around communication, care environments, timeline and continuity of care/ carer and trusting relationships. Reflection also allowed recognition of the impact of not receiving care underpinned by TI principles and the risk of re-traumatising during their maternity care experience. In addition, it is known that these challenges can also create barriers to families receiving appropriate support or disclosing their trauma experience to allow the development of their own individualised, care plan. It should also be noted that families may fear disclosing issues such as domestic violence or mental ill health, if it is perceived that the disclosure may impact on child protection decisions around parental capacity to provide appropriate, safe care.

1.6 Workforce Training Needs Analysis

A workforce that is able to recognise where an individual may be affected by trauma and work in a way that minimises distress and maximises trust can do two things:

1. Support the recovery of people affected by trauma by providing them with a different experience of relationships. People with LLET identify that the most important part of their recovery was developing a safe and trusting relationship with a worker thus making them more likely to seek further support.

2. Minimise the barriers to receiving care, support and interventions that those affected by trauma can experience when memories of trauma are triggered by aspects of the service or interactions with staff. Thus contributing to people finding it easier to navigate and engage with the services/ systems that they require, support and strengthen their resilience and improve outcomes.

A workforce training needs analysis (TNA) survey, to measure local self-assessed levels of understanding, knowledge, skills, and confidence about TIP within the Pathfinder Maternity Services, was distributed to all the workforce across maternity and neonatal services. The survey explored the following key themes:

- Background information: place of work, role, and length of experience within maternity settings.
- Understanding, experience, and confidence in providing TI care in their practice.
- Trauma Informed Practice as an organisation.
- Workforce wellbeing policy, supports and initiatives.
- Identified barriers to adopt TIP.
- Identified supports required for the service to become TI.
- Knowledge and access of the NTTP and associated training participated.
- Examples of existing TIP for families.
- What individuals/ service are hoping to gain from the pathfinder project.

The survey aimed to inform organisational readiness to become TI and help inform the development of an appropriate Maternity and Neonatal training programme across the workforce. It sought to provide a baseline against which changes in staff understanding, knowledge, skills, and confidence in providing TIP could be assessed in future.

Despite senior maternity staff representatives encouraging workforce participation on numerous occasions over a 3-month period, uptake of the survey was challenging across both pathfinder boards. Final response rates were 33% of maternity staff in Board 1 and 11.4% of Board 2. Therefore, findings cannot be seen as representative but provide some insight into training needs which align with findings from the NMAHP and pathfinder initial scoping exercises. Key TNA findings suggest:

- Less than a third of respondents in either board (22-30%) were previously aware of the NTTP. With only three participants in one board and fifteen within other having completed any of the training courses or accessed materials related to the NTTP.
- Between 23-57% of respondents expressed a lack of confidence in understanding and applying principles of TIP
- Between 20-38% of respondents thought TIP values were evident in their service and 13-17% felt that leaders championed TIP. Given the current context within the NHS, leaders' focus has been on ensuring safe levels of staffing to deliver core services.
- That only a third or less of respondents in either Board felt encouraged to undertake TIP training, likely reflects the current context within the NHS in terms of workload, demand to cover for staff absences and loss of staff within the service. Within the scoping element of the pathfinders, it was evident that fulfilling mandatory training was a huge challenge for the Board areas. Securing protected time for training and coaching is therefore a substantial challenge for anyone wanting to roll out TI practice and one all organisations are required to address.

- Few respondents (9-13%) were aware of activities to engage those with LLET in their services design and delivery. This element of the NTTP also requires substantial support and expansion, if NTTP ambitions are to be achieved.
- Whilst around half of respondents thought staff wellbeing was supported, the remaining staff were either ambivalent or disagreed that this was the case. Given the current context (absences, understaffing and retainment challenges) within the NHS and the learning from the scoping and wellbeing drop-in phases of the pathfinders which reinforce these themes, staff health will require to be prioritised as a key element of the NTTP roll out.
- Coaching was reported by 10 -13%, with supervision provision varied across teams. Frequency of supervision was reported to be reduced due to workforce challenges and the impact of the recent pandemic.

Many examples of existing good TIP were provided from respondents and evident during the pathfinder projects despite the challenging circumstance that services and staff were facing. For future progress of TIP, it seems likely that many of the current structural barriers such as workload, demand, staffing levels and environment challenges, which have impacted on staff training, wellbeing and the capacity of leaders and staff, will need to be addressed. Recognised good trauma-informed practice included:

"Having a talking therapy service out with psychological therapies, where people may need to discuss previous traumas. Also, the inclusion of dads and families as we sometimes tend to forget them, but not meaning to."

"We offer family centred care, parents are not visitors they are essential care givers"

"Fully explain the process of and reasons for any procedures. Always offer chaperone for intimate examinations"

2. Phase Two: Improvement Planning

Following completion of a comprehensive familiarisation process, discussed in phase one of the project, leaders are required to consider how they can take the key learning to build their local improvement plans in their journey to become TI. The process the pathfinders followed in developing their long term service improvement plans is detailed below.

2.1 Organisational Self-Assessment and Improvement Planning

Many people with LLET highlighted the importance of the care setting feeling welcoming, safe and accessible, offering choice on their care and care provider, developing care plans in collaboration, helping them feel respected and, building a trusting relationship. By considering a person's journey through their pregnancy, considering all their interactions, relationships, environments and resources, and taking this learning into their service design, services can actively resist re-traumatisation and support recovery.

When planning TIP change ideas it is important to embed feedback loops to create an ongoing dialogue between the organisation and people who work in, alongside or come into contact with the service. Pro-actively and routinely encouraging feedback from these groups helps the service understand how they can continue to reduce barriers to accessing support.

Within the maternity pathfinders, the MTISG were supported to review their current service provision using two maternity specific implementation resourses, designed during the project. These were, 'Creating trauma informed change in maternity services: Implementation guidance and planning resource'[7] and 'Implementation guidance for trauma informed care in Scotland: A tailored self assessment resource for maternity services'[8]. These tools helped the leads to consider the key drivers for organisations and to deliberate on their current status against these when developing their improvement plans. The resources supported the steering group to consider how to align their implementation plan in line with findings from phase one: Understanding service context and readiness, change ideas from the 'Trauma Informed Lens Event' and learning from those with LLET.

Workforce challenges significantly impacted the pathfinders ability to progress both their self assessment and planning with the trauma-informed specialist and evaluation expert faciliating and supporting the steering group through the guidance and processes.

2.2 Developing Theory of Change (ToC) Model (See Appendix B - Theory of Change Model)

It is important for services to take time to consider how they can effectively and efficiently start to implement their identified change projects /plans to become TI. Developing a ToC supports the improvement aims by agreeing the desired outcomes and providing an agreed programme theory about what needs to change to achieve these. The visual diagram is a useful tool to help teams develop and communicate their change theory over a longer-term timeline. It articulates what parts of the system should change, in which way, and includes evidence-based activites to make this happen. It is used to help plan improvement project activities and ensure team engagement,

[7] https://learn.nes.nhs.scot/71464

[8] https://learn.nes.nhs.scot/71463

while providing a framework to inform future evidencing of progress. Within smaller services, the development of action plans may be sufficient.

Learning from the pathfinder's familiarisation activities, in particular the 'Trauma Informed Lens Event' and organisational self assessment, provided many change ideas/ activities which aligned with the TI drivers. These all contributed to the following overarching outcomes:

- Trauma informed practice is sustainably embedded across all maternity systems and services with effective cross-sector collaboration;
- Health and wellbeing of those affected by trauma (who use, work in or with maternity services) is improved;
- Reduced inequalities and improved life chances for those affected by trauma (who use, work in or with maternity services).

The pathfinders MTISG were supported by both the specialist in Maternity TIP and Monitoring and Evaluation, to develop their five year + ToC model through several in-person activities, with representation across the departments as previously discussed.

Both maternity pathfinder IJBs had very similar ToC plans, activities and change ideas, reflective of maternity services nationally. These models considered the core TI drivers being suggested within the NTTP which can be aligned with the developing Roadmap. Roadmap drivers include: Culture, Leadership, Workforce care, support and wellbeing, feedback loops and continuous improvement, Powersharing with those with LLET, Workforce knowledge skills and confidence, budgets, policies and processes, and services design and delivery.

Having an understanding and experience in Quality Improvement (QI) and implementation science is helpful for services to develop their ToC and associated change ideas that embed measurement plans and reporting structures. Capacity and experience within the pathfinder boards impacted the steering groups ability to progress this work in the absence of the specialist leads. The newly developed Roadmap provides a national ToC that services can use and adapt in combination with a action plan templete.

2.3 Implementation of Trauma-informed Practice Priorities

It is important when implementing change ideas and actvities that the QI process is central to the progression. It involves a systematic and coordinated approach to implementing change using specific methods and tools with the aim of bringing about a measurable improvement.

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Following activities and learning from Phase one: ‘Understanding service context and readiness’ and development of their local ToC model, the priority areas of transformational change within both pathfinder areas were identifed as:

- Workforce development;
- Workforce wellbeing;
- Screening and documentation of disclosed trauma.

Identified activities within their ToC plan required further detailed planning to support implementation through development of, topic specific driver diagrams, logic models and measurement plans for each of the three areas above. This recognises the vast transformation process required within the overall pathfinder ToC and breaks this down into meaningful and realistic actvity plans.

To support this process, in recognition of the limited knowledge and experience in QI, the specialist TI experts facilitated several in-person events that developed their understanding of QI and the Implementation journey, supported through the use of NES QI resources accessible through TURAS.

2.4 Enhancing Documentation, Policies and Processes

Policies and processes provide clear guidelines to staff and people coming into contact with services about how the organisation operates and its values and culture. Evidence highlights that successful implementation of TI knowledge and skills into practice needs to be reinforced by policies and processes that "hard wire" the values and principles of a TI approach into the way the organisation works, not solely relying on training workshops or a well- intentioned leader.

If the workforce are constrained by protocols or policies that do not recognise the impact of trauma, they may be unable to minimise the risk of re-traumatisation that their training has taught them to recognise. This can risk moral injury for staff, as well as potentially feeling disconnected from their work and a sense of helplessness. It is also important for organisations to consider where there might be tension between a trauma-informed approach and existing organisational policies by exploring where flexibility, choice and collaboration with staff and people affected by trauma could be built into policies and processes.

Early familiarisation within the pathfinders sourced their services leading documents inclusive of: Best Start: A Five Year Forward Plan for maternity and neonatal care in Scotland, The Promise, GIRFEC and National guidance for child protection in Scotland. Policies that focused on employee wellbeing or that included TI principles within, were unknown to many of the staff engaged, identifiying a need for a focus group to review local policies from across both their organisation and department. The maternity implementation resources provide guidance for leaders to consider how they approach their review of their policies, guidelines and processes.

Unfortunately, the workforce challenges and capacity of senior midwives to participate in this activity impacted any progression within this theme/driver. Discussions with the pathfinders to identify senior midwives to participate in processing this activity was encouraged and will be a focus over the next year.

3. Phase Three: Implementation of Priority Areas

3.1 Workforce Development

Trauma Informed Leaders

TI organisations require leadership that understand, drive, and inspire TI change, embody the key principles, and build accountability for long-term improvement. This requires leaders who; understand the prevalence and extent of the impact of trauma on people and services, create and actively sustain accountability, infrastructure and implementation support and model a culture of choice, empowerment, collaboration, trust and safety through their own behaviour and attitudes. The Scottish Trauma Informed Leaders Training (STILT), is a crucial resource to equip key leaders to support and lead transitional change.

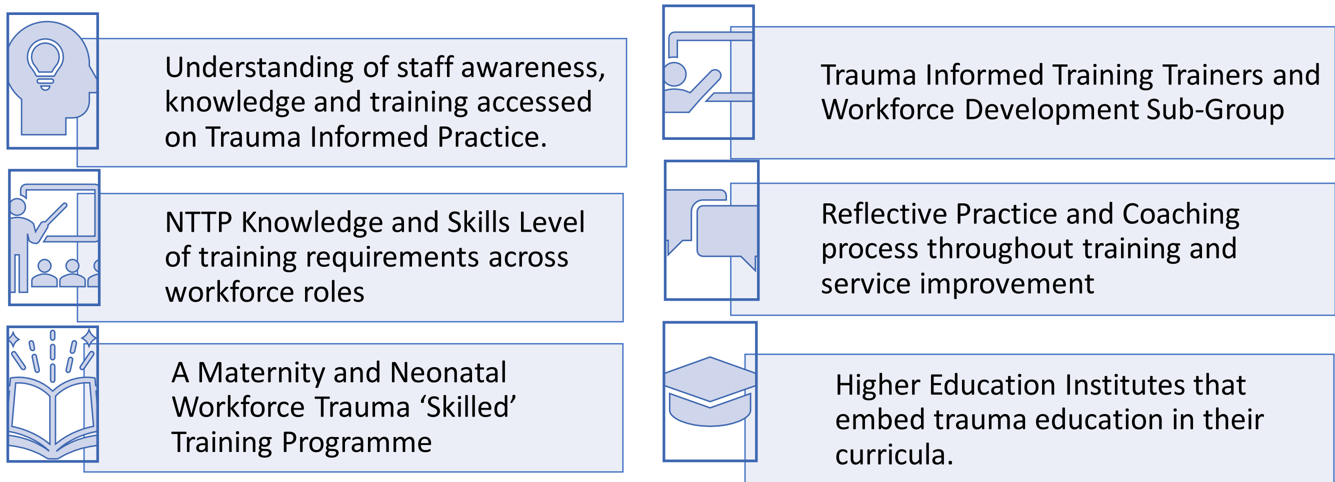
The STILT learning programme supported leaders from the maternity pathfinder MTISG through access to action learning workshops and ongoing implementation support from the Improvement Service and local TPTICs. STILT provides links with their local champions to support a joint commitment to TI practice across their IJB and wider Scottish workforce in partnership with Scottish Government and COSLA. Workforce challenges impacted the ability for many group members to access the training, however notification of future sessions are shared regularly with the hope other members can access it over time.

Workforce Development Implementation Planning (Appendix C Workforce Development Driver Diagram

All staff require the knowledge, skills, confidence, and capacity to recognise, and respond to people affected by trauma. Leaders who understand workforce training and implementation needs directed through the NES Psychological Trauma Knowledge and Skills Framework and training plan resource is paramount. Access for all staff to training relevant to their role, supporting transition of learning into practice.

Review across both pathfinders TNAs highlights the need for development of a ‘trauma-skilled’ level training programme for the core maternity and neonatal workforce. The programme would encompass all four NES ‘Developing your trauma-skilled practice’ and wellbeing resources with embedded reflective practice and coaching sessions to support learning into practice.

The implementation group were supported to develop a 'Workforce development' driver diagram and logic model, to plan additional activities required to facilitate learning across the workforce. These identified key secondary drivers required to facilitate change activities:



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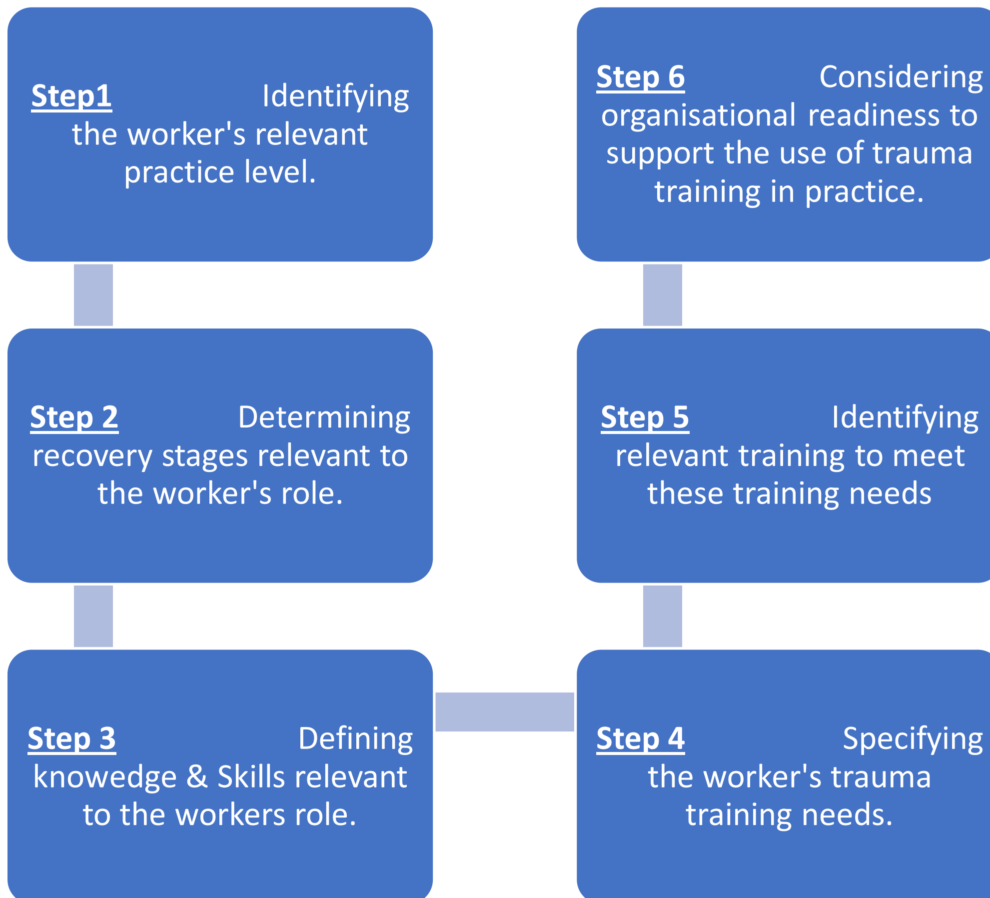
The Implementation groups were supported to identify a sub-group of members from maternity workforce development, TPTIC's, specialists with trauma experience and MNPI's, who will lead on the workforce development change ideas and agreed training programme. These members will provide feedback to the MTISG.

Development of a Maternity and Neonatal Tailored 'Skilled level' Trauma Training Programme

The level of TI training required across the maternity workforce is determined by their unique roles and responsibilities and should be guided through the NES Knowledge and Skills Framework, previously discussed. It is essential that individuals have the level of training required. The NTTP aspiration is that all workers across all service sectors will develop a TI level of understanding and skill. 'Workers who have regular contact with children or adults who may be affected by trauma (even if this is not known about) would develop a trauma-skilled level of understanding and skill'.

Using the Trauma Knowledge and Skills Framework



The maternity TI expert at NES used the NTTP training plan resource to guide level of training required across the maternity and neonatal core workforce, identifying a requirement for all staff to have training at a 'skilled level'. Some practioners were noted to have more enhanced contact with families with LLET within their area of speciality such as PMH, early pregnancy, public protection or substance use, requiring further assessment of their training needs in addition.

The training programme was developed from the six 'skilled-level' E-learning modules produced by the NES NTTP, consisting of four e-learning modules that support the understanding of the impact of trauma and how to develop a trauma-informed approach, and two e-learning modules focusing on promoting worker well-being and psychological first aid. Thus combining learning activities that develop understanding on requirements to become TI as well as building the important conditions through developing their own wellbeing and principles of implementation science. In recognition of maternity interventions increasing the potential risk of re-traumatisation, the recently updated 'One out of four' E-module was also included.

The programme structure is based on Implementation science with embedded reflective practice and coaching sessions. Running over a 10-week period, it has been designed to be facilitated virtually with protected time to access the range of Skilled level training modules through practioners' TURAS accounts. These include:

- Four Microsoft Team sessions to introduce new concepts, consolidate learning from E-Learning Modules, and for participants to share learning, key insights and start to consider transition of learning into practice;
- Three periods of protected time to access self-directed learning, including E-Modules, videos, online resources and supporting documents;
- Monthly coaching forum on completion, to support workplace-based application of the principles of TIP;
- An online community which will provide a secure space where information and resources can be posted and shared, and an opportunity for discussions and networking between participants within their service.

The training programme commenced by addressing workforce wellbeing supports inclusive of 'Staff Wellbeing: 'Taking care of yourself' e-learning and developing own wellbeing planning tool and the 'Psychological First Aid' (PFA) module. This facilitated engagement, through challenging times, while embedding early wellbeing initiatives.

Within one board area, members of MTISG accessed the planned modules from the training programme to assess priority learning that would be feasible to include due to ongoing workforce challenges and service capacity. This led to a shortened version of training that excluded 'Developing your trauma skilled practice' modules 2 – 4. These modules focus on more specific aspects of trauma such as trauma in children and young people, the mental health impact of trauma and understanding substance use as a coping strategy. However, the final Team session shared key messages from these modules and encouraged participants to access modules to enhance their learning.

It was agreed that the Maternity TI Project lead would facilitate the training with initial cohorts of 15 participants, identified by their service, to evaluate the training efficiency and compare any implications of the shortened programme. Pre and post course confidence surveys were completed by particpants to assess impact of each of the modules with Team sessions activities supporting the overall programme evaluation.

Ongoing workforce pressures impacted some participants' ability to attend all sessions. However, sessions were recorded with permission and shared within their cohort/Teams community. Allocation of participants differed with one board allocating staff linked to a central work rota and the other allocating staff voicing an interest. Evaluation of the programme's impact saw a clear postive shift on the workers' confidence across all the key components of the learning. There were higher positive levels of change particularly around psychological first aid, understanding the window of tolerance, producing their own wellbeing plans and understanding the impact of trauma on mental health.

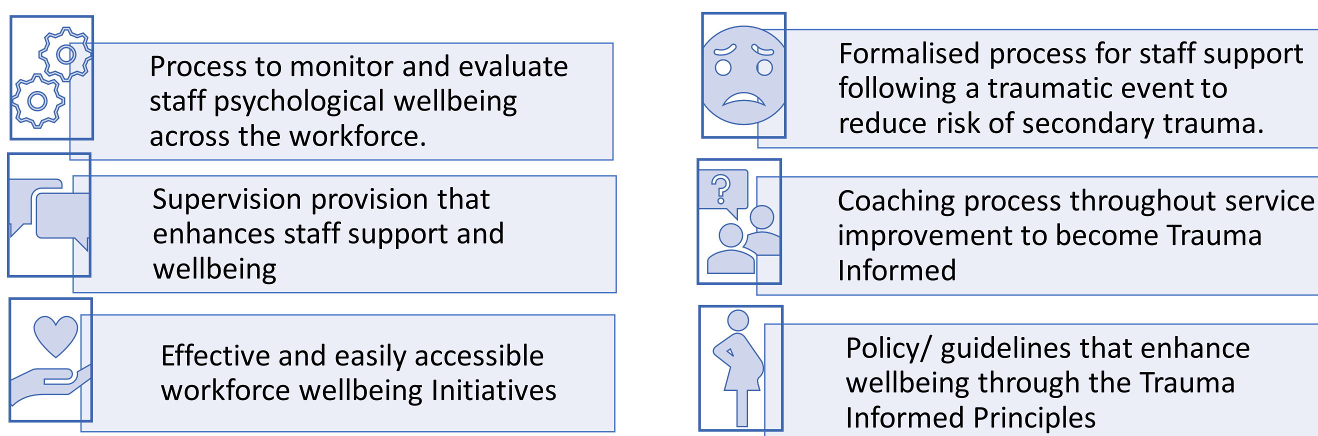
The maternity service accessing the full 10 week programme have trained two cohorts and had two post training coaching sessions with learners embracing new change ideas that they are keen to implement. The shortened maternity service pathfinder have trained four cohorts, with a higher drop-out rate, and no attendance at planned coaching session to-date, reflecting competing workforce challenges.

3.2 Workforce Health and Wellbeing (Appendix D Workforce Wellbeing Driver Diagram)

Wellbeing is critical for a TI workforce, across departments and roles. Creating a healthy workplace culture is vital, where staff feel safe, supported and well when they are supporting others. Workforce care, support and wellbeing is particularly important for workers directly supporting people affected by trauma, and/ or who work in roles where they may be exposed to traumatic experiences, or face an increased risk of experiencing vicarious trauma, moral injury and compassion fatigue. Without the necessary proactive measures (e.g. supervision, reflective practice) and reactive (e.g. action plan for responding to critical events) in place, the challenges in supporting people affected by trauma can often leave us feeling disconnected from our values as practitioners and can impact our safety and wellbeing. The workforce needs to be well to be able to support others.

Nationally reported NHS workforce pressures, recruitment and retention of staff can impact on both the organisations' and workforce wellbeing as was evident within both maternity pathfinders. This highlighted the importance of the initial focus of pathfinder support to be targeted towards the 'workforce wellbeing' TI driver. Findings across all the Phase one activities to help understand the services' readiness to implement TIP, highlighted the importance of enhancing wellbeing initiatives that are effective, accessible and are informed by the workforce.

Wellbeing initiatives were noted to be championed and enhanced within both pathfinders during the recent COVID pandemic. However, there appeared to be a disconnect with the key workforce accessing these. The MTISG produced a driver diagram, logic model and associated change ideas that aimed to support staff wellbeing. Identified secondary drivers concluded the need for:



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Activities commenced from the driver diagrams within the pathfinder timeline have included:

- Facilitation of workforce wellbeing drop-in sessions, allowing an anonymised platform for the workforce to feedback on their experience in accessing or receiving local area supports. Identifying most effective supervision processes, barriers and enablers to accessing support iniatitives, suggested new activities they would find helpful and an opportunity to provide new ideas.

- Embedding of their own wellbeing planning tool and Psychological First Aid, within the Maternity and Neonatal Skilled level training Programme. With reflective practice and coaching sessions to support transition of learning into practice.
- Findings from the drop-in sessions have been shared with both areas 'Supervisor of midwives', maternity senior leads and their organisational wellbeing groups to assist the development of a more efficient and effective supervision programme for their workforce.
- Development of a Peer Support Wellbeing Sub-group.

During the lifespan of the pathfinders, it had been an aim to trial the use of the 'Professional Quality of Life' (PROQOL)[9] questionaire which assesses the impact of work-related stress on compassion satisfaction and compassion fatigue. The 5 minute validated tool, provides the participants a personal report on their risk assessed score's for compassion satisfaction, burnout and secondary traumatic stress with immediate associated self-help appendices to support the individual. This tool is thought to provide a platform for clinical leaders to obtain insight staff wellbeing and further develop appropriate support mechanisms to prevent, compassion fatigue, secondary traumatic stress, and staff burnout.

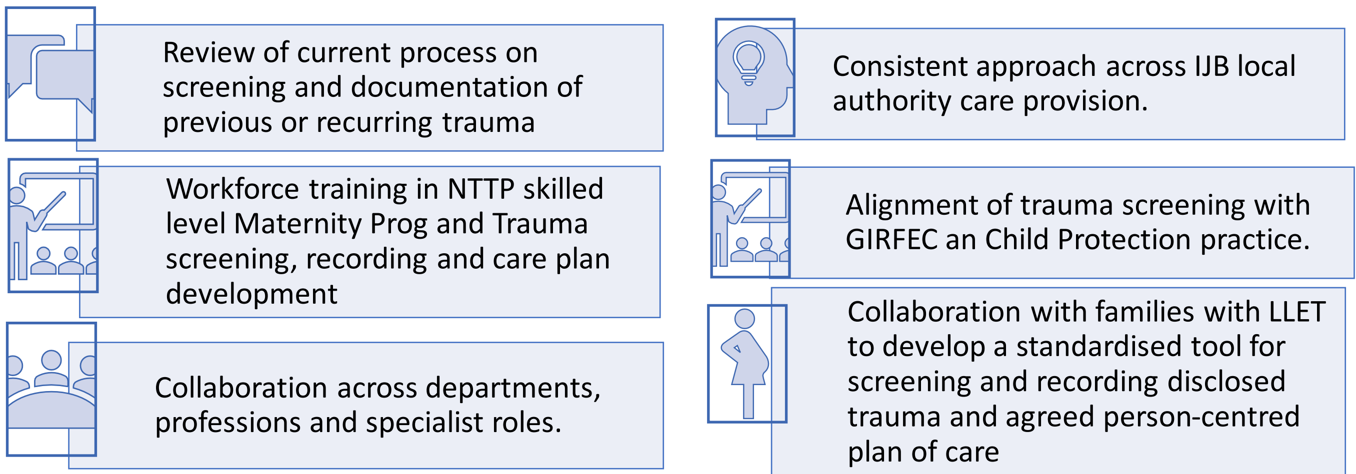
Support from NES Clinical Governance and Information sharing team have been working in collaboration with both IJB clinical governance leads on developing an agreed Data Protection Impact Assessment prior to use within the services. The PROQOL has been replicated at NES, and both boards are in agreement to trial use going forward. An internal report on learning from this process has been provided to the commissioners.

3.3 Screening, Documentation and Care Plan Implementation (Appendix E Screening Driver Diagram)

Support that helps individual recovery often comes from engagement with peers, family, communities and services. Where care providers share power and collaborate with people with LLET in developing their unique care plans, the evidence supports that this can help people's recovery through developing trusting relationships and knowing that their expertise about their life is valued. Providing a platform where individuals feel safe to share their trauma experience and are supported to develop plans that will reduce risks of re-traumatisation is beneficial. Organisations that embed TI principles throughout their care will also improve the experience for people who may not feel able to share their trauma event.

Within the timescale of the pathfinders, the MTISG have reviewed learning from the voice of those with LLET and their development of their understanding of implementation of the TI principles, to produce a driver diagram, logic model and change ideas with an aim that 'All pregnant women residing in their geographical Board, who have experienced/ or are experiencing trauma are identified and supported to develop person-centred maternity plans of care'. With recognition that midwives have embedded practice that aligns with 'Getting It Right for Every Child' (GIRFEC) and 'Child Protection' processes that involve screening for some previous traumas, the primary driver aim was for the 'Maternity and Neonatal Services workforce to have appropriate knowledge and skills to Recognise, Respond and Record women's experience of Trauma'. The identified drivers to achieve this included:

[9] https://proqol.org/



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The identification of key representatives to develop a sub-group or focus group to lead on this work included specialist roles supporting families with high incidence of trauma, public protection, community midwifery, maternity digital leads, MNPI and 3rd sector supports such as Maternity Partnership Voice. These representatives are identifed as key roles that can identify and connect families they are supporting to participate in the development of guidance on screening, documentation and care plan development.

The timeline of the pathfinder support has not allowed progress of this area of work to date but has been recognised as a priority area over the coming year. It is anticipated that this driver will entail a great deal of commitment and resource but is an essential area of transition.

4. Summary of Learning and Recommendations from the Maternity Pathfinders

Learning from the pathfinders has helped inform the development of an NTTP Roadmap which has been in production during the timeline of the pathfinder. The Roadmap aims to support organisations across Scotland, regardless of sector or purpose, with implementing TI change project. The Roadmap will support organisations to undertake a self-assessment to identify progress, successes and good practice, while identifying areas for improvement in their journey to embedding a TI approach. The nine key themes that the Roadmap explores are vital in creating the culture, environments and ways of working that can resist re-traumatisation and support people's resilience and recovery from trauma. Learning across these themes from the pathfinders is highlighted below.

4.1 Organisational Culture

Enablers	Barriers
Use of improvement planning tools aid identification of stakeholders supporting families during pregnancy. Ensuring involvement of all stakeholders helps enhancement and consistency of multi-agency TIP /culture.	COVID and associated service changes have significantly impacted workforce wellbeing and staffing, with high absence rates and poor staff retention.
The Trauma Informed Lens event supports core workforce to reflect on care provided and build plans to enhance TIP and culture.	Reduced staffing levels have impacted demands on the workforce with members reporting more stressful working conditions.
Newly developed MNPI and PMH services embrace TIP and culture.	Team working has been impacted through the Pandemic and is still recovering.
Maternity Best Start Policy centres 'continuity of carer' in developing maternity care and culture.	Despite implementation of workforce wellbeing initiatives, there is a disconnect with staff accessing these.
Early scoping sessions and Trauma Lens event evidence many good examples of TI practice and culture embedded in maternity care that can be sustained/expanded.	Surveys such are 'I-matter,' or 'culture' aimed at enabling staff and leaders to develop a nurturing supportive culture are reported to be ineffective with little change implemented following completion. This leads to despondency and survey / engagement fatigue.
GIRFEC and Child Protection process and working provide an open culture to further develop TIP.	Workforce understanding of TIP and the psychological impact of traumas, out with birth related trauma, found to be lacking.

Recommendations

Consideration should be given to addessing workforce challenges and competing agendas which may impact progression of developing both TI practice and culture through associated change activity.

Key structural challenges that should be considered as part of wider organisational culture include issues such as: protected time and resource for staff training; enhanced workforce wellbeing

supports and working conditions that allow uptake of these; capacity to extend time for appointments with vulnerable service users; improving communication and information sharing across departments, agencies and care timelines and, prioritising care versus organisational needs/department activity.

Maternity services should explicitly recognise that families are supported by many professionals across their pregnancy resulting in a need for largescale culture and service change and development across professions and services to fully achieve TIP. Without commitment and representation across professions and services, implementation of change may be impacted, increasing risk of retraumatisation to families supported.The following settings/services and their associated cultures are key to the success of TIP:

- Inpatient setting
- Community Setting
- Midwifery / Obstetric Specialist Support
- Triage / Interm care
- Neonatal setting
- Perinatal mental health and MNPI
- Health Visitors
- Scan Department

Maternity services regularly support families with a variety of trauma incidents, therefore education and learning needs will vary across these areas/specialisms and will be a part of culutral change.

4.2 Leadership

Enablers	Barriers
Early project planning, meetings and communication support identification of key stakeholders and leaders at all levels of the organisation.	**As detailed above in culture**
Development of MTISG to lead and be accountable for project planning implementation and evaluation.	Leadership capacity to drive forward the pathfinders was difficult and may impact sustainability.
Subject specific subgroups to drive forward implementation of themed activities such as wellbeing, workforce development etc.	Focus of strategic/ operational leaders on ensuring safe and appropriately staffed services evident but challenging.
Representation across departments and professional roles.	Leaders were not always aware of some aspects of NTTP / drivers such as policy or environments.
Development of meeting terms of reference and hosted through Microsoft Teams and in-person.	Evidence of some disconnect between embedding new initiatives and workforce engagement of these.
STILT learning programme and support from IJB TPTIC and Champions.	Methods of communication across workforce.

Recommendations

When progressing TIP, early engagement with key stakeholders across the pathfinder IJB, at both a strategic and operational level of leadership, is essential to facilitate a shared understanding of project components and to obtain commitment and ownership from the onset. Engagement should be inclusive of all services/ agencies involved in caring for families throughout pregnancy and the initial postnatal period. Identification of a senior maternity member as the main project contact with responsibilty to feedback progress and learning from the pathfinder activity to Senior stakeholders within their board is also vital.

Implementation groups should be supported to identify sub-groups of members from maternity workforce development, TPTIC's, specialists with trauma experience and MNPI's, who will lead on the prioritised change ideas. These members will provide feedback to the MTISG.

The following key representitives should be involved throughout all pathfinder meetings:

- Senior midwifery across departments
- Obstetrics, neonatology and anaesthestics
- Allied health professionals
- Health visiting Team Leaders
- Public protection
- Family Nurse Partnerships (FNP)
- Children and families social work services
- Perinatal / community mental health
- Addiction services
  - Maternity and neonatal psychological Intervention (MNPI)
  - Higher Education Institutions (HEI)
  - Key 3rd sector organisations
  - TPTIC's and Trauma Champions.

Early engagement and communications would involve :

- An overview of NTTP and Maternity TI Pathfinder project aims, objectives, core elements and timeline.
- Sharing 'Organisation Window of Tolerance' and links to TI leadership and workforce.
- Establishing MTISG with appropriate representatives, Identifying routes to involve people with LLET.
- Providing a TPTIC update on local NTTP delivery activity.
- Initiating discussions around local/ national policy / strategies and links to TIP.
- Agreeing plans for multi-agency familiarisation sessions to help understand systems, structures and multi-agency working.

4.3 Staff Care Support and Wellbeing

Enablers	Barriers
Midwifery trained' Supervisor of midwives'(SOM).	Nationally reported staff shortages and skill mix.
Mandatory supervision with reports of 'open access' as required. Support from line managers / peers.	Workforce retention, absence rates and reported fatigue.
FNP professional supervision embraces TIP.	Time restraints due to workforce challenges.
Policy for Supervision within Boards.	Absence of a 'Safe space' availability.
Provision of Child Protection Supervision.	Unstructured and irregular Supervision.

MNPI's have role in supporting staff following birth related trauma incident.	Wellbeing initiatives 'not feeling supportive.'
Workforce Wellbeing as a key driver to TIP, is a key catalyst to start engagement to becoming a TI organisation.	Impact of COVID pandemic at a professional and a personal level.
Taking care of yourself e-learning and developing own wellbeing planning tool and the Psychological First Aid (PFA) module facilitate engagement while embedding new wellbeing initiatives.	Pandemic implications resulting in silo working reducing peer support and reflection.
Development of Workforce wellbeing driver diagram, logic model and change ideas support planning and evaluation	Absence of structured 'ongoing' support for workforce following involvement in a traumatic event and initial 'Hot debrief.'
Sub-group of SOM, team leaders, coaches and MNPI to drive forward change ideas.	Inconsistent or absences in supervision, reflective practice and other 'pro-active support'.

Recommendations

Workforce wellbeing is a priority area to be addressed prior to implementation of new change ideas, embracing a TI culture that nurtures and supports its workforce, embracing the TI Principles.

Identification of key staff members with a role to support staff or colleagues and have the knowledge and experience to provide a range of supervision supports, is fundamental within the development of a sub-group to lead on workforce wellbeing change. Within maternity, various roles from supervisor of midwives, team leaders, MNPI's or Child Protection specialists have been identified.

Workforce drop-in sessions are an effective process to allow the key workers to have a voice on most appropriate form of support, barriers to access and identified new iniatitives. This will allow the development and implementation of more accessible and effective interventions. Survey fatigue and workforce engagement may present a barrier.

Embedding the NES existing workforce wellbeing modules within training plans, supports engagement of staff and provides new workforce wellbeing supports while highlights the importance of self care. Within maternity settings, the learning has suggested a need for a review and redesign of a more efficient supportive provision which encompasses clinical supervison, reflective practice, coaching and peer support components. This should be aligned with national guidance.

Organisational challenges and culture has been highlighed as a barrier to the workforce feeling able to access appropriate supports when required. Systems are required to address these barriers and help promote a nurturing, caring environment with staff who feel able to say 'its ok to not be ok' and receive the support they require.

4.4 Feedback Loops and Continuous Improvement

Enablers	Barriers
Supporting MTISG to review their service provision through the Maternity TI Implementation resources allows reflection on changes applied.	Workforce challenges impacting capacity to progress self-assessment and planning.
Alignment of their implementation plans with findings from the scoping interviews, change ideas from the 'Trauma Informed Lens Event,' learning from those with LLET and the TNA results.	Lack of expertise in quality improvement and project planning to consider change ideas and develop PDSA cycles with embedded measurements and feedback loops.
Development of a strategic ToC model to set out TIP activities; short and interim service outcomes and potential longer-term contributions to local organisational outcomes and national impacts.	Ability to collate ongoing robust data to inform service change may be impacted by both lack of knowledge of process and capacity to gather data and data systems that do not link or align
Newly developed Roadmap.	Culture and staff confidence to voice change, barriers and enablers is important and can often be a challenge.

Recommendations

TI Implementation steering groups ideally require members with a firm understanding and experience of quality improvement (QI) and implementation science. This may be maternity specialist roles such as Maternity and Children's Quality Improvement Collaborative (MCQIC) or from their local board QI Team. Consideration on identifying a Maternity lead for the project who has QI experience or supported to complete training in QI would support and sustain the longevity of transitional change.

Embedding data measurement plans and feedback loops from the onset, which are regularly reviewed and adapted, would support the services to assess the impact of their change ideas and adapt as required.

Inclusion of the voice of those with LLET is essential when developing their ToC and change plans and their input should be encouraged/reflected on throughout the project transition journey. A TI approach that supports existing work around local priorities, with feedback loops and power sharing processes to inform what's working/ not working in our service.

Within larger organisations, ToCs can highlight the longer term transition to become TI, however recognition of the scale of change within these plans and the services ability to progress these must be addressed. Production of more 'bite size', realistic and achievable driver diagrams, individual project logic models and measurement plans support the implementation team to progress priority areas. Smaller services or departments may find action or improvement plans to be more suitable to their needs.

Development of project planning resources is more effective through in-person sessions as the process is reliant of visual tools and group working. These processes require commitment across

all departments and roles to be effective. Collaboration with local area TPTIC and champions can support this work.

4.5 Power sharing with People with Lived Experience of Trauma

Enablers	Barriers
Collaboration across services and roles aids identification of families with LLET to be included.	Disconnect from existing feedback from families with LLET within other services to maternity services.
Collaboration with 3rd Sector organisations and Maternity Partnership Voice (MPV).	Experiences known to retraumatise often create barriers to disclosure of trauma or accessing support.
Connection to existing processes to hear the voice of those LLET e.g., FNP, 3rd Sector organisations, some specialist roles.	Collaboration to hear the voice of LLET to inform service change and delivery were found to be fractured and rarely informed required changes.
Inclusion of families in developing ToC, planning and change ideas.	Much of the third sector support relies on volunteers found to be relatively unsupported.
Confidential 1:1 session for families to share their experience supports identifications of good TIP and areas to be developed.	Fear of child protection processes and being seen as 'unfit' to parent may create further barriers to disclosure and engagement.
LLET can be a priority area to review existing screening of trauma, documentation and developing plans of care that are TI. Feedback shared anonymously.	Little evidence of power sharing processes currently embedded in maternity services.

Recommendations

Services should aim to always provide TIP whether there is known trauma for the individual or not. It should be recognised that disclosure is not always easy for women/individuals attending maternity services.

Services require early recognition of possible high incidents of specific traumas relevant to their area of work and families using their service. Early scoping recognised that the maternity workforce can have a focused understanding of trauma linked exclusively to pregnancy or birth, such as miscarriage, loss or traumatic births. However, awareness of the psychological impact of wider single incident or complex trauma, such as ACEs or gender based violence was lacking. Workforce development to increase knowledge and understanding of these wider issues will help identify families where collaboration and feedback loops exist and can subsequently be embedded.

Multi-agency scoping sessions also highlight, that despite many partner services working alongside the maternity workforce who had embedded processes that heard the voice of those LLET, there was a disconnect to maternity services in terms of informing service change. Engagement with all key agencies is pertinent to scope existing feedback mechanisms that can be built on.

Power sharing with families with LLET is essential from the onset. Those with LLET and agencies who support them should be encouraged to work in collaboration with maternity service redesign related to their care.

4.6 Staff Knowledge, Skills, and Confidence

Enablers	Barriers
TNA is a good platform for the key workforce to provide their perception on their organisations readiness to become TI in addition to scoping existing knowledge.	Maternity workforce often has a focused understanding of trauma linked to pregnancy and birth.
Existing TI training in IJB – TPTIC and Champions.	Limited understanding of the psychological impact of trauma such as ACEs or GBV.
STILT accessible for identified leaders and members of MTISG.	TNA evidence limited knowledge of NTTP, resources or TI Principles.
NTTP 'skilled level' existing resource applicable to maternity setting.	Workforce challenges impacting ability to access training or implement new learning.
Knowledge and Skills Framework and Training Plan support assessment of individual training needs.	Training with reflective practice and coaching is a relatively new concept of learning in maternity.
Maternity and Neonatal Trauma-skilled Training programme provided knowledge across a range of topics in addition to TIP.	Evidence of survey fatigue which can impact on TNA and evaluation of new TI training programme.
Implementation science (reflections and coaching) supports transition of learning into practice.	Training on Implementation science: coaching and reflective practice is essential.

Recommendations

Services are encouraged to recognise key leaders within their organisation with a responsibilty to support the transition to become TI, who will attend trauma informed leaders training and supported coaching sessions in collaboration with their local TPTICs and Trauma Champions. It is recommended that key representatives are selected across the organistions departments and professions to access STILT.

A workforce TNA is required to assess accurate workforce knowledge, practice, and service provision in line with TI principles to inform appropriate training plan specific to their service. This combined with NTTP knowledge and skills framework and associated Training Plan, will guide role specific level of trauma training required. Senior members across the workforce are required to encourage the participation of all their staff in a TNA, to provide a more accurate assessment. The TNA is also a good platform for the key workforce to provide their perception on their organisations readiness to become TI by identifying enablers, barriers, leadership support structures and existing workforce health and wellbeing initiatives.

The development of a service-specific sub-group to champion and drive all workforce development activities would support more effective implementation of training requirements. This is encouraged to align with the NTTP resources and local area TPTIC. Within maternity, the pathfinders have identified a workforce development role with the newly developed Clinical

Psychologist MNPI's and will be invaluable within the sub-group. Members with coaching training and experience in reflective practice facilitation would support connection to training provision, learning and impact on implementation of TIP.

When designing a training programme it is advised to be mindful of the current workforce challenges and realistic capacity for training commitments. Consider commencing training with NES wellbeing and Psychological First Aid modules, aligned with the TI principles, as this would support engagement with the service transition while providing the workforce with iniatives that will support their wellbeing.

The programme of training needs to be realistic and achievable for the organisation, particularly through the current challenging times. It is also recommended that the content is applicable to the learning needs of the service, particpants and roles. Embedding reflective practice and coaching structures that are setting specific, are vital to support transition of learning into practice that are meaningful and 'owned' by the core workforce.

Early identification of a team of trainers to facilitate the ongoing programme of training delivery is essential for sustainability. This will also allow identification of any additional training requirements they may require such as coaching. Consideration of development of a 'train the trainer' programme to develop a national cohort of champions to deliver the maternity programme nationally would support the drive and consistency across Scotland Maternity services.

Recognition that some practioners will require additional training due to their speciality and role supporting families with higher incidence of LLET is important and planning to meet their needs is essential both for the practioner and the family.

4.7 Policies and Processes

Enablers	Barriers
Learning from the TI Lens event and familiarisation activity support identification of key policies and guidelines for review.	Policies not recognising the impact of trauma and may be seen to constrain the ability to provide TIP.
Maternity Implementation resources provide guidance on identification and review of policies.	Risks to moral injury to staff due to restrictions some policies enforce.
Strategic policy and guidelines such as Human Resources or Wellbeing Policies.	Did Not Attend guidelines and closure to some service support, not recognising impact of trauma.
IJB TI Steering group learning and process.	Restrictions to referral criteria to some services.
Support from local TPTIC and Champions	Impact of the pandemic on key maternity policies implementation.
	Capacity for leadership to participate in review of policies and guidelines in challenging times.

Recommendations

Consideration is required in how to effectively review policies, guidelines and processes during challenging times where organisational capacity is limited. Identifying a small team of leaders to focus and drive the process forward over a realistic and obtainable timeline would be recommended.

A focused session with the Implementation Steering group, which has representation across departments and roles, would be effective to identify key policies, guidelines and processes to be reviewed. Learning from the 'Trauma Informed Lens' event and the 'workforce drop in session' will provide further areas to be reviewed. It is essential to scope policy outwith the maternity service that can impact them such as Human Resources.

4.8 How we Design and Deliver Services

Enablers	Barriers
All phase one familiarisation activities provide a platform to evidence TIP and areas to be developed.	Care provided across several local authority areas with varying processes and provisions often restrictive.
TI Lens event allows each department to consider their area of practice and develop and own change plans to become TI.	Availability of suitable accommodation to provide TIP.
Continuity of carer model supports TIP and helps builds trusting relationships (Best Start).	Competing agenda/ priorities and/ or major local areas changes e.g., new hospital development.
GIRFEC screening process provides an existing platform to screening for past or existing trauma.	Inconsistencies in accessing effective services due to referral criteria or place of residence.
Person-centred care plans and birth planning through informed choice, are embedded in midwifery practice in collaboration with families.	Technology challenges / collaborative interfaces impact communication, patient journey, and TIP.
Embedded pathways of care with risk assessment and planning are embedded systems.	Maternity concerns in most appropriate place to record disclosure of trauma within the Badgernet system. Need to be consistent to reduce risk of families having to retell their story.
Newly developed specialist support teams e.g., PMH and MNPI.	Capacity and sustainability for long term improvement and service change.
ToC development with; change ideas, short/ medium/ long term outcomes and link to national TI long term visions.	Limited knowledge, experience in Quality Improvement and improvement science to progress implementation in absence of specialist support.

Recommendations

A TI Roadmap has been in development during the timeline of the pathfinders and will support services during their self assessment and improvement planning. As the Roadmap is being

developed to be applicable across all organisations and services, it is recommended that the maternity specific resourses are used in addition within this setting.

It is important to recognise that organisational self assessment and improvement planning requires a detailed ‘Phase 1’ familiarisation and scoping exercise to inform their planning and attempting the implementation phase independent of these may not be as effective.

The NTTP TI Lens Event resource is a great tool for services to consider their position in providing TIP and facilitates department/ service specific change ideas meaningful to the workforce who will implement the change. These findings will aid development of their Theory of Change Model. It is recommended that the event is facilitated over a day to allow meaningful and important discussions to occur and appropriate time to develop their plans and change ideas. Given the varied pathways and timeline for families supported through their maternity journey it is essential to expand the event across professions, departments and teams. Inclusion of families with LLET, who are/ been supported by the maternity service, is paramount to help inform transition to become TI across the varied trauma experiences identified is essential.

The use of Improvement planning tools such as stakeholder analysis and communication plans, combined with early leadership communication, will support identification of key personnel to be included. Without commitment and representation across professions and services, implementation of change may be impacted, increasing risk of retraumatisation to families supported.

Consideration should be given to workforce challenges and competing agendas which may impact progression of change ideas and associated activity. Development of subject specific sub-groups should be considered to progress activities such as, workforce wellbeing and workforce development. These focused groups would drive forward the change ideas and feed back to the MTISG. Identification of senior representives across services and departments, who will feed back progress to their wider service is of benefit. Services may consider an identified role to lead on this work locally with support from a national lead expert for TIP in maternity.

Collaboration with the local TPTICs and trauma champions is recommended to learn from IJB process and support multi-agency local service development.

The review of current practice on screening and documentation of disclosed trauma is pertinent to understanding change requirements when planning practice change. Identification across the varied trauma screening questions and documentation suggests capacity is required to understand any limitations to the existing recording process eg. Badgernet, the digital platform used within maternity and neonatal services.

Development of an identified lead sub-group across departments with enhanced knowledge on the needs of families with LLET will support facilitation of the change ideas and engagement of/ collaboration with families known to the service. Within the maternity setting, it is vital that changes within documentation, multi-agency information sharing and agreed care planning align with GIRFEC and Child Protection, keeping the child at the centre.

4.9 Maternity Pathfinder Outstanding Drivers

It is recognised that due to the ongoing development of NTTP Roadmap there will be a need to update learning and align it with updated/additional drivers. The maternity pathfinders will be

encouraged to assess their progress against the Roadmap when launched. Further focus will include a deeper understanding in relation to; leadership, culture, budgets and powersharing with those with LLET.

4.10 Maternity Pathfinder Key Learning Summary

MATERNITY KEY LEARNING

- Phase one familiarisation activities provide a platform to evidence existing TIP, areas to be developed and aids organisational assessment and planning.
- Inclusion of all professionals, recognised to support families across their pregnancy, supports enhancement and consistency of multi-agency TIP /culture.
- An implementation steering group, with representation across services/ departments, to lead project planning implementation and evaluation is essential.
- The STILT learning programme and collaboration with local TPTIC / Champions enables service leaders to drive forward implementation of TIP.
- TNA is a good platform for the key workforce to provide their perception on their organisations readiness to become TI whilst scoping existing knowledge.
- Development of a Theory of change model to set out TIP activities with short/interim/ long term service outcomes, facilitates implementation planning.
- The Trauma Informed Lens event supports the core workforce to reflect on care provision and build meaningful plans to enhance TIP within their area of work.
- Newly developed MNPI and PMH services embrace TIP and recognised as an essential addition within maternity and neonatal services.
- The maternity 'Best Start Policy' centres 'continuity of carer' in developing maternity care and supports embedment of TIP.
- Maternity holistic booking assessment process, using GIRFEC principles, provides a good platform to build disclosure of previous or recurring trauma.
- An initial focus on development of a Workforce wellbeing driver diagram with change ideas, not only support planning and evaluation but was found to be a key catalyst to engagement towards implementation of TIP.
- Workforce wellbeing sessions were effective, allowing them to have a voice on the most appropriate form of support, identify barriers and suggest new initiatives.
- Embedding wellbeing learning/ resources within the training programme, facilitate engagement while also embedding new wellbeing initiatives for the workforce.
- Scoping allowed recognition of existing processes to hear the voice of those LLET across agencies such as FNP, 3rd Sector organisations, some specialist roles.
- Anonymised 1:1 session for families with LLET to share their experience, supports identifications of existing TIP whilst identifying areas requiring developed.
- Collaboration with families with LLET is a priority area to review existing screening of trauma, documentation and developing plans of care that are TI.
- 'Maternity and Neonatal Trauma skilled Training programme' developed from existing NTTP module is, provides knowledge across a range of topics in addition to TIP.

5. Conclusion

Nationally reported NHS workforce pressures, recruitment and retention of staff, and their impact on both the organisation and workforce wellbeing was evident within both maternity pathfinders, directing an initial focus of pathfinder support to be targeted towards the 'Workforce wellbeing' driver with associated support activities. This provided a platform that initiated conversation, considered early change ideas embracing TI principles, while developing more accessible and effective workforce wellbeing initiatives.

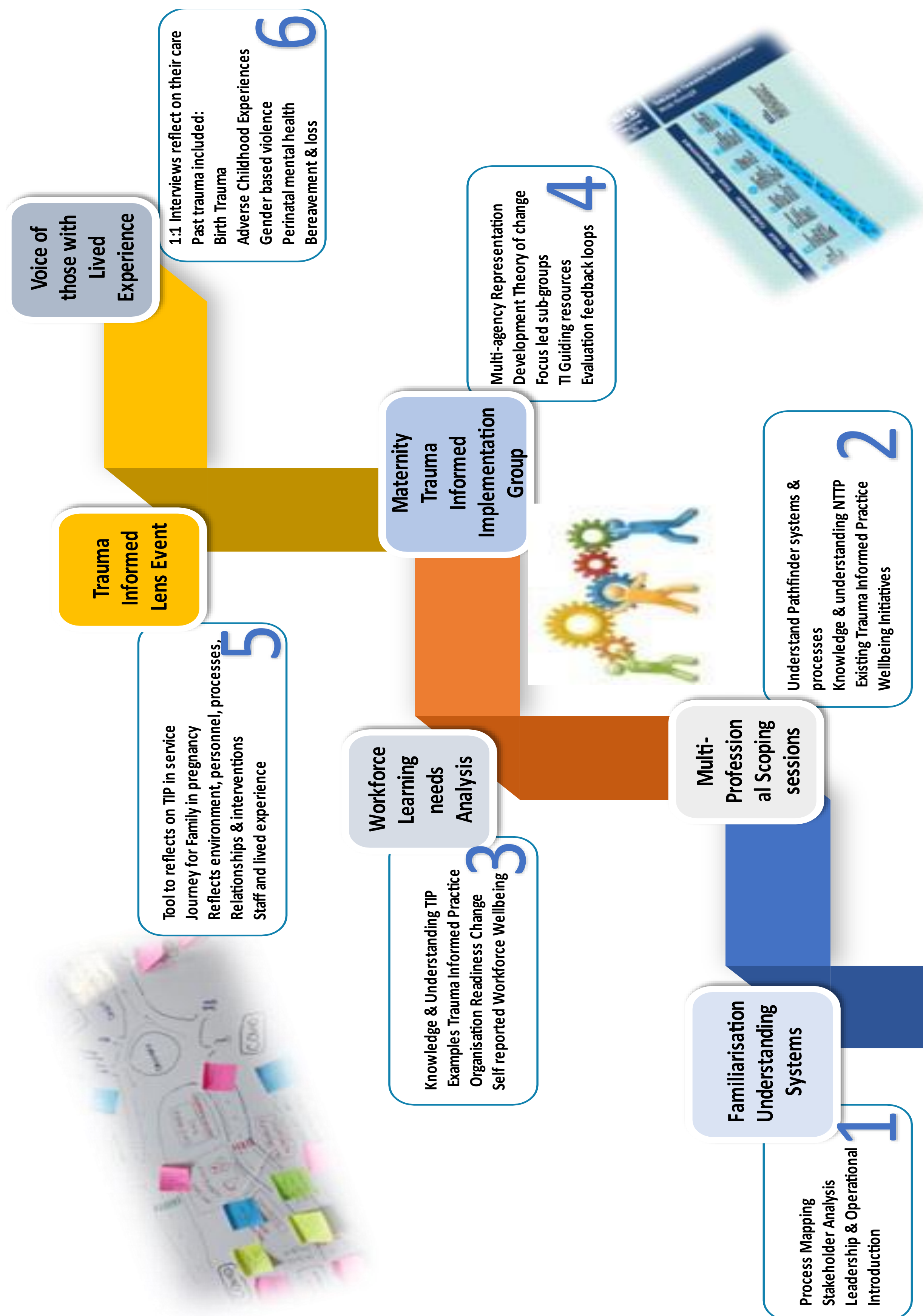
Development of an implementation steering group, with representation across services and departments recognised to support families across their pregnancy, who will lead project planning, implementation and evaluation, is essential in supporting an enhanced and consistent multi-agency TIP and culture.

Existing NTTP e-learning modules and implementation supporting resources were transferrable to the maternity setting, supporting the pathfinders to develop a Maternity and Neonatal Trauma Skilled Training Programme and helped inform improvement planning. Embedding reflective practice and coaching sessions have provided the opportunity to consider, plan and implement new learning into practice, with evidence of early activity occurring.

Activities that are inclusive of those with LLET are essential in informing implementation planning with feedback loops. Pathfinder familiarisation activity identified many existing processes, from services within and who work alongside maternity services, that provide reflection on experience from families accessing the service that required connection to better inform changes required in the service.

It is recognised that due to the ongoing development of NTTP Roadmap there will be a need to update learning and align it with updated/additional drivers. The maternity pathfinders will be encouraged to assess their progress against the Roadmap when launched. Future focus will include a deeper understanding in relation to leadership, culture, powersharing with those with LLET and routine enquiry of trauma.

Appendix A: Familiarisation and Scoping Road Map



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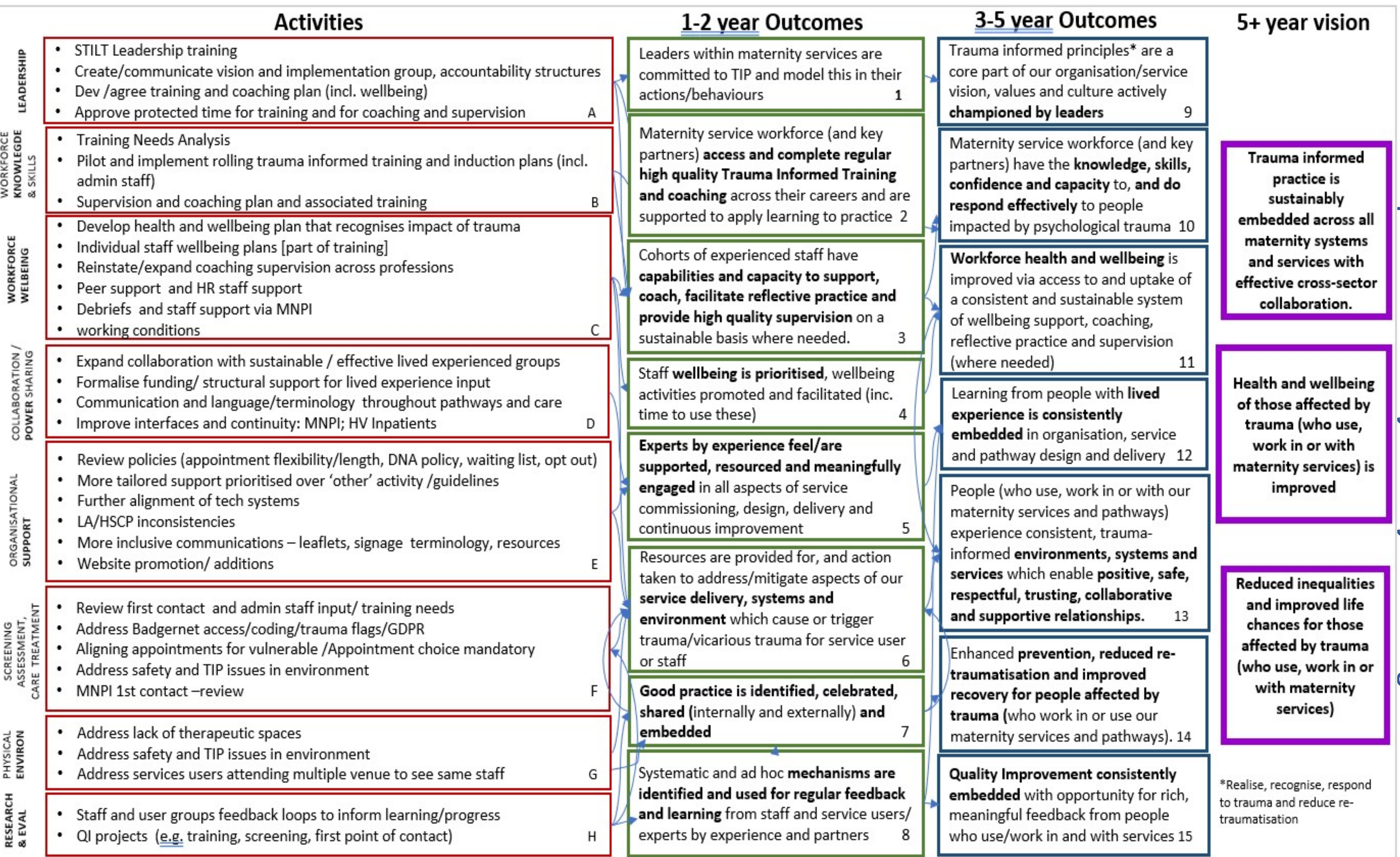
Appendix B: Example of Maternity Theory of Change Model



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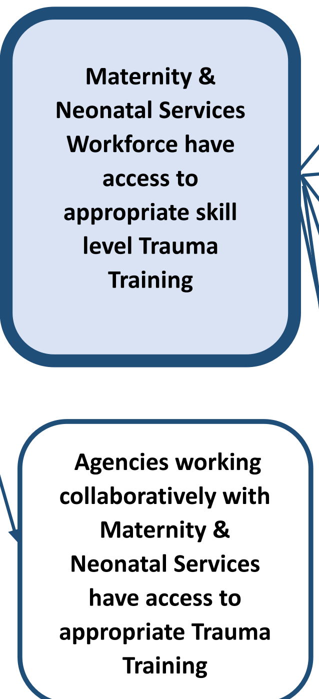
Appendix C: Workforce Development Driver Diagram

AIM
In order to achieve aim...

All Maternity Service Workforce & key partner agencies have the knowledge, skills, confidence, & capacity to respond effectively to people impacted by psychological trauma by ...

PRIMARY DRIVER
We need to ensure ....



Maternity & Neonatal Services Workforce have access to appropriate skill level Trauma Training

Agencies working collaboratively with Maternity & Neonatal Services have access to appropriate Trauma Training

Expectation that agencies have responsibility for providing TI training for staff. Consideration of inclusion of agency staff in in-house training

TI Workforce Development Sub-group
Trainers who, as part of their remit champion for NTTP awareness & liaise with managers to ensure staff are supported in accessing training

SECONDARY DRIVER
Which requires ...

- Understanding of staff awareness, knowledge & training accessed on Trauma Informed Practice.
- National Trauma Training Programme (NTTP) Knowledge & Skills Level of training requirements across workforce roles
- A Maternity & Neonatal Workforce Trauma 'Skilled' Training Programme
- Trauma Informed Training Trainers & Workforce Development Sub-Group
- Reflective Practice & Coaching process throughout training & service improvement to become Trauma Informed.
- Higher Education Institutes that embed trauma education in their curricula.

PDSA / Change Ideas
Ideas to insure this happens... ...

- Workforce development Training Needs Analysis
- Shared learning from Neonatal Trauma Informed Care
- Assess role specific NTTP level of training required using NTTP 'Knowledge & Skills Framework' & 'Training Plan'
- Identified Maternity Leaders to access NTTP Scottish Trauma Informed Leadership Training (STILT)
- Collaboration with TPTIC's, Trauma Champions Steering Group & MNPI's
- Development of a 10 wk. Trauma 'Skilled' level training Programme that embeds all NTTP Skilled Level Training resources, Reflective Practice & Coaching.
- Cohort of 15 Core Staff to trial new training programme with pre & post evaluation on efficiency to inform next phase
- Liaise with NES NTTP Leads on additional training requirements for those working with higher level Trauma
- Embedding of TI Training within Induction Programme
- Identify staff members trained in NTTP delivery (min Skilled Level), Coaching Reflective Practice and **or** has a Workforce development remit to form TI Subgroup / Trainers
- Develop Workforce Development Plan / Training schedule in collaboration with TPTIC & MNPI
- Review requirements for specific 'tier level' training across professional roles in collaboration with area managers to providing 'Benchmarks' for specific training delivery.
- TI Training Programme embedding coaching & reflection
- Monthly TI Coaching Sessions to facilitate Service change following completion of training.
- Assigned Practice Lead with recognised ringfenced time to oversee TI Programme (lead in coaching/supervision/reflection.
- Collaborate with HEI Leads Training content Midwifery Students
- Student representation within TI Implementation Team

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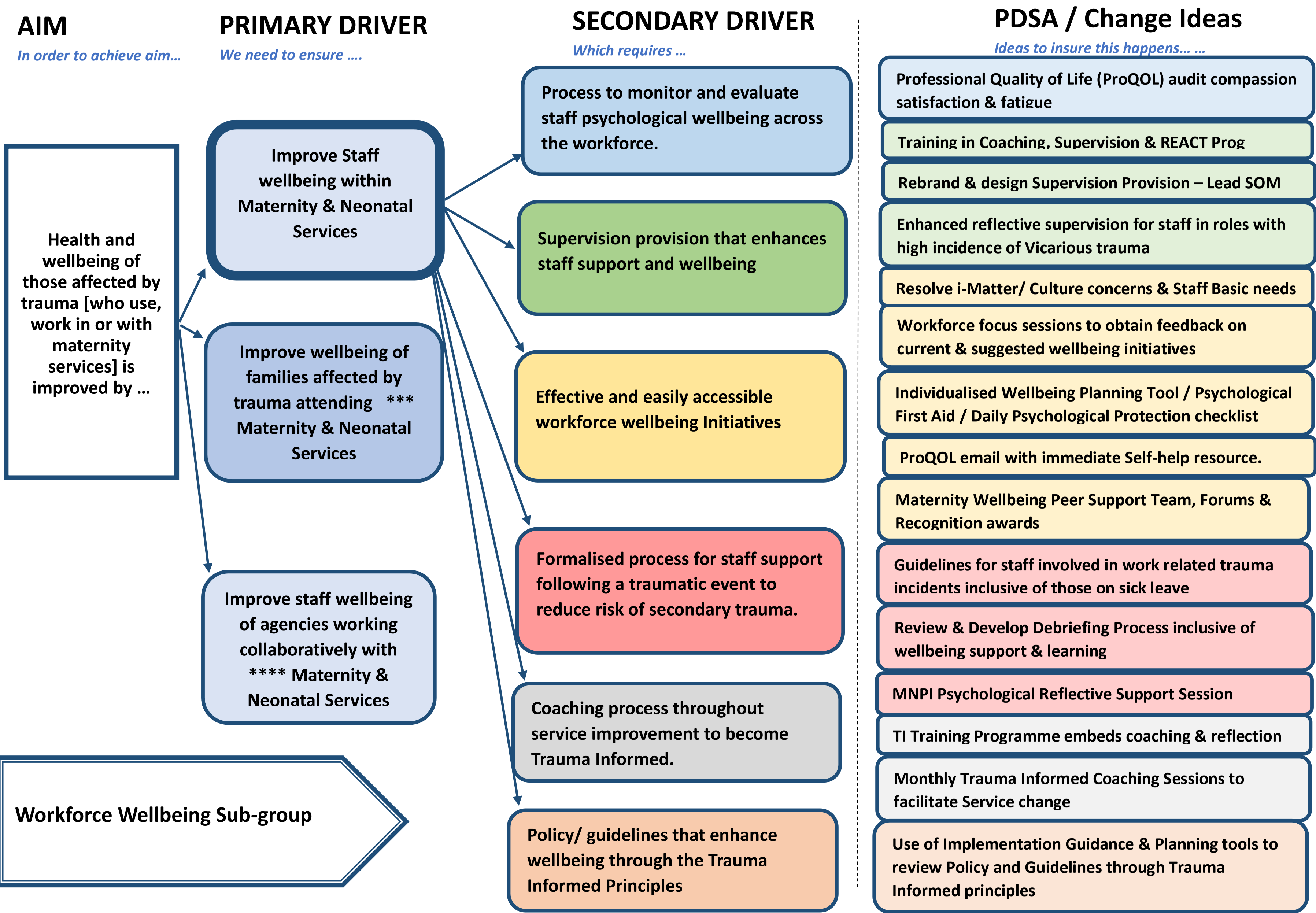
Appendix D: Workforce Wellbeing Driver Diagram



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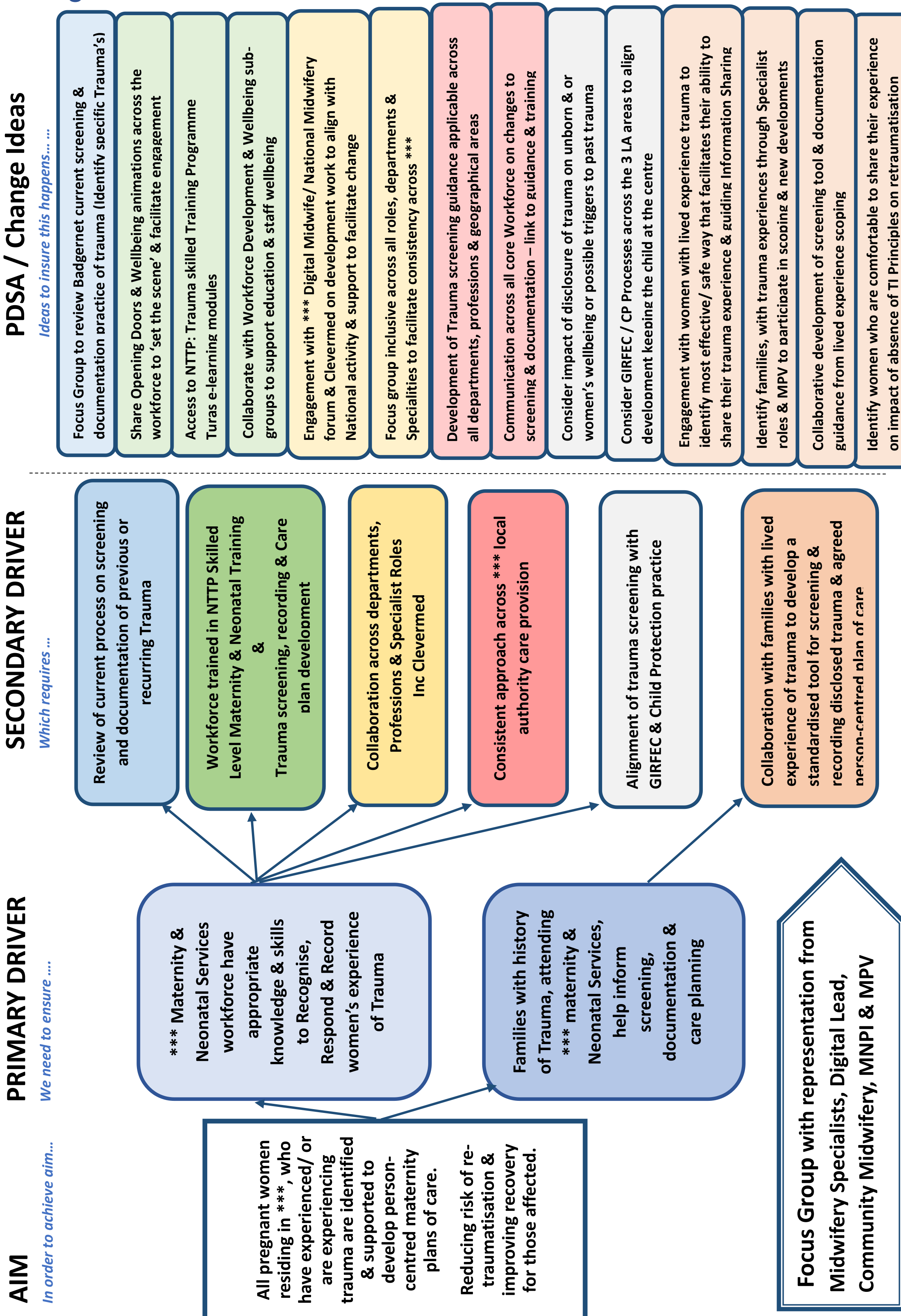
Appendix E: Screening, Documentation and Care plan Implementation Driver Diagram



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