

Implementing handovers and huddles: a framework for practice in maternity units

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Introduction

This document provides a structure for maternity units to create and develop their own approach to effectively communicating clinical data and transferring key safety information. It describes the difference between handovers and huddles, the benefits of effective clinical handovers and the role of huddles in promoting safety. It is intended as a good practice guide for healthcare professionals involved in the care of pregnant women and their infants, regardless of the nature of the unit they work in or whether it is in the community or a hospital. It recognises that each unit will have its own culture and ways of working.

Caring for pregnant women and their babies requires all maternity staff to work effectively in multidisciplinary teams (MDTs) with agreed shared objectives. The Kirkup report¹ recommended improvements in teamwork and communication in maternity services. Evidence shows that a structured, consistent approach adds value to frontline clinical services and improves safety.^{2,3}

Each baby counts (2017)⁴ highlighted the need to maintain situational awareness through effective communication using clinical handovers and huddles. However, a survey of obstetric and midwifery labour ward leaders for the ATAIN (Avoiding Term Admissions Into Neonatal units) programme⁵ found significant variation in structure, frequency, MDT representation and timings of clinical handovers and huddles. Some described the two processes as one and the same.

The evidence underpinning huddles and clinical handovers is at a relatively early stage and does not always originate in the NHS. We have highlighted where such evidence is available and signposted additional resources.

Huddles or clinical handovers: how do they differ?

The terms 'huddle' and 'clinical handover' are sometimes used interchangeably, but in this document we describe their similarities and differences.

Handovers are distinct from huddles both in terms of purpose and information shared (see Table 1 below). The National Patient Safety Agency⁶ defined clinical handovers as involving a “transfer of professional responsibility and accountability for some or all aspects of care for a patient, or a group of patients, to another professional or professional group on a temporary or permanent basis”. The most important point of handovers is the efficient transfer of clinical information during transfer of clinical responsibility. Effective handovers should include a succinct overview of:

- current inpatients:
 - their risk level
 - their location
 - status of their investigations and treatment
 - any proposed clinical management plans to be implemented during the duty shift
- patients expected from triage or home or transfers from other units.

Handovers often start with a brief huddle highlighting operational issues. Though this is not a clinical handover's main purpose, it is a good opportunity to make all team members aware of any safety issues.

Huddles in healthcare are short briefings where team leaders come together to share clinical information, review events and plan for the day ahead across disciplinary borders and services, while maintaining individual clinical responsibility. For example, managing the elective caesarean section lists and the induction-of-

labour workload on a day when emergency activity has been high would be a topic for the huddle.

Huddles focus on:

- sharing key general information to increase all team members' situational awareness (eg planned theatre work)
- improving patient flow (eg available neonatal cots)
- identifying patient safety concerns, including staffing.

Table 1: Comparison of handovers and huddles

	Clinical handovers	Huddles
Purpose	Sharing clinical information with the aim of handing over clinical responsibility for some or all of patient care.	Sharing information to improve the team's situational awareness while maintaining role-appropriate clinical responsibility.
When	Usually end of shift or when the staff member responsible for patient care changes (eg covering for meal breaks or change in staffing). Also required when patient is transferred to another setting (eg to postnatal ward or intensive care unit).	Usually once or twice a day once staff on duty are familiar with their workload and patient concerns and are alert to expected problems.
Information shared	Largely patient-specific clinical information such as observations, progress in labour or newborns' Apgar status. Clinical handovers can incorporate a safety briefing highlighting patient safety concerns, but their focus is sharing clinical information and the plan for care during the episode of care. Specific patients needing urgent or regular review should be highlighted.	Depends on the level of the huddle. At all levels, the huddle will highlight any safety and resource concerns that can affect the smooth running of the unit or department in the coming 24 hours and may choose to focus on safety, flow and person-centred care.

	Clinical handovers	Huddles
Who	<p>Depends on situation and staff group and should be tailored to the unit's needs. May involve an incoming complement of midwives on a new shift. There may be a 'board' handover, then individual midwives may meet their patient and family with the midwife going off duty. Medical staff in the delivery suite may hand over to incoming medical staff, and the senior midwife may participate as she has an overview of the whole situation on the labour ward. It is helpful if other medical teams participate, such as anaesthesia and neonatology, to identify patients at high risk and make plans with all expertise available.</p> <p>One-to-one handover in maternity care should involve women and their partners, so they can understand the plan of care and raise any issues that concern them.</p>	<p>Reflects the unit's needs and complexity but should include the delivery suite co-ordinator, neonatal consultant and nurse in charge, person(s) responsible for theatre/anaesthesia, staff responsible for triage unit, antenatal wards, postnatal wards and community midwifery oversight.</p> <p>If occurring across two sites, those on each site should be involved. This may be done via conference call but should have the same rules of timeliness and focus.</p> <p>A macro-level huddle across an organisation or region may need to be done by conference call. It should remain focused and identify those involved who can solve problems.</p>
Timescale	<p>Clinical handovers share information relevant to the incoming clinical team for the following shift. Longer-term plans are seldom discussed, with decisions focused on more immediate problems. In some situations, a more complex case may need an MDT planning meeting, which should be convened separately.</p>	<p>Huddles should focus on looking forward to the next 24 hours and beyond to predict any issues that may affect the smooth running of the ward or department. They may look backwards to unexpected outcomes, but this should not be the huddle's key purpose, which is staff and patient safety and initiating any investigation.</p>

	Clinical handovers	Huddles
The team and the time taken	<p>Clinical handovers are typically longer than huddles, to discuss each patient handed over. A structured clinical handover improves both efficiency and completeness. However, even the most efficient clinical handovers last at least 30 minutes.</p> <p>Despite multidisciplinary handovers demonstrating improved communication and a reduction in missing key information,⁷ clinical handovers remain largely within professional groups.</p>	<p>Huddles are brief (10 to 15 minutes maximum) and should always be multidisciplinary to increase the whole team's situational awareness.</p>

Foundations for successful huddles and clinical handovers

Deciding the purpose

Be clear about the objective of a team meeting: this will help you decide if it is to be a clinical handover or a huddle which, in turn, will decide the audience. With a clear purpose, structure and outcome, individual 'buy-in' is much easier and the meeting can break down silo working across professional groups, encourage open communication and build trust.

Neonatal consultant on the power of huddles

“Knowledge is power, and it helps us understand the pressure across our service rather than operating in silos where all we see is what we have got here. Over time it became apparent to people who engaged [in huddles], the actual benefits to their service, that if they were the most pressured service... through the huddle they were able to identify support.

You may want someone from service management to be there. Their role would be looking at additional support in terms of service capacity, staffing.”

Focusing on purpose can also help you define why you are holding the meeting. In handovers, the concise, structured communication of clinical details promotes the safe transfer of clinical responsibility. The reasons for holding huddles may be less tangible. Analyses of adverse incidents often cite lapses in non-technical skills as causes;⁸ these may be, for example, a fixation on a specific task resulting in failure to recognise a patient's clinical deterioration, or fear of speaking up within a strictly hierarchical team. It is this aspect of patient safety that huddles address. By

seeking key team members' perspectives and promoting psychological safety to voice concerns, huddles can enhance the whole team's situational awareness.

Psychological safety

For huddles or handovers to be effective, team members must all feel they will be heard. The key elements to promoting psychological safety include:

- **Culture:** encourage a culture that puts safety first, where individuals feel confident to talk openly about errors and where asking for help is seen as a strength and not a weakness.
- **Team composition:** communication has a psychological and emotional element. Understanding what makes the team 'tick' in various circumstances will help you recognise how best to engage the individuals in it. Teams invariably have a hierarchy, but an effective facilitator will flatten it by creating familiarity, encouraging participation and listening when someone speaks up.
- **Communication:** communication involves talking **and** listening. Huddles and handovers must give team members an opportunity to contribute. The language we choose should actively invite participation and avoid confrontation. "Have I missed anything?" may be more effective than "Any questions?"

To have the confidence to speak up, team members must believe that their opinion will be considered and valued. A team may need to agree a common form of words that unconditionally creates the safe space in which to speak up. This may be a scale of escalation: "I'm concerned – I'm uncomfortable – I feel this is unsafe" or a key phrase such as "You need to stop and listen to me". The 'Listen to Me' campaign is a well-embedded example of this (see Appendix 2: 3.6). Uncivil, derisive and unprofessional behaviour can threaten the team's psychological safety. A key responsibility of the facilitator is to ensure respectful, open communication.⁹

Situational awareness

Both huddles and handovers are about communicating information. This, in turn, builds situational awareness and aids decision-making. However, it is surprisingly difficult to define situational awareness or measure it objectively. A colloquial

definition is 'knowing what is happening around you and what is about to happen', and it is sometimes referred to as a 'mental model'.

Situational awareness has three recognised levels:¹⁰

- perceiving the situation (eg recognising an impending high risk pre-term delivery on a busy delivery suite)
- understanding the situation (eg understanding the need for multidisciplinary input for both mother and baby)
- projecting the situation (eg mobilising midwifery, obstetric and neonatal teams through clear, effective communication).

Senior midwife on the benefits of huddles

“When you are working on two sites, you can get a balanced opinion on what is going on across both sites and overall it can balance up the workload. Also, for the women, it is very safe, so it means they are going to the right place at the right time.

Since we started huddles, as bleep-holder, it gives me a really good overall picture of what's going on. It allows me to communicate effectively with my colleagues. It means that I am not ringing up blind to find out what's going on in either site/area. It has improved communication with the neonatal [team] immensely. Apart from anything else, you get to know people, so getting things done is an awful lot easier.

You do need sign-up from the doctors as well as the midwives. That can be one of the hurdles... people not understanding the benefits... [I am] constantly selling it to some of my colleagues. They don't see the point, but that may be because they are still in their own little world and we need to pull them out.”

Huddles and handovers are important opportunities to build situational awareness in both the team and the individual. The huddle should be the place to exchange overall case-mix information, welcome challenge to decisions and resolve differences in individual mental models within the team. The team, with a shared mental model, will then be in the best position to anticipate and avoid an unsafe situation.

Effective handovers

Transferring information is key to delivering person-centred care and is vital in the modern working environment, which does not always permit continuous responsibility. Missed or incorrect information can lead to serious consequences.¹¹ Units may use paper and electronic tools in the handover, and many have modified existing tools for their own use.

Handovers occur at many levels, including:

- handover of an individual patient:
 - paramedics and ambulance crews hand over to the triage midwife
 - midwife-to-midwife handover of care on admission and at shift changes
 - one profession handing over to another when escalating care or if specialty input is necessary
 - on discharge
- handover of all patients in a clinical area:
 - changing shifts requires handover of all patients in a clinical area to one or more professional teams
 - this is often followed by one-to-one handover of individual patients (either from midwife to midwife from one shift to the next, or on a ward round from midwife to the obstetric team).

All trusts have a policy on effective handover that individual sites can adapt to ensure handover is fit for purpose in each unit. This is an element of care the Care Quality Commission includes in its inspection programme, and numerous sources offer guidance on what constitutes effective handover.¹²⁻¹⁵ However, the way handovers are conducted varies substantially,¹² suggesting that units must continue to evolve the best way to do it. This document focuses on the handover of clinical areas between teams, but the principles also apply to handover between individuals.

Effective huddles

Huddles can occur within and across organisations and should look forward unless an untoward outcome prompts reflection on immediate safety concerns. Each huddle gathers information so the team can plan the day ahead. Huddles can occur at different levels, and sometimes it helps to consider how to apply this to a specific maternity setting, depending on the nature of the service and the organisation in which it operates. Goldenhar et al (2013)⁷ describe three levels of huddles.

Micro level

Micro-level huddles occur on wards and are often incorporated into the beginning of a handover. An example might be the World Health Organization's (WHO) theatre safety huddle¹⁶ before elective surgery, modified for maternity use. Issues raised may include:

- patients with similar names
- equipment
- staffing
- new guidelines
- changes in procedure.

Who should attend will depend on the situation; an antenatal and postnatal ward or community setting may involve only midwifery and support staff. However, in a delivery suite or theatre it is vital the huddle is multidisciplinary and involves anaesthetic, theatre, obstetric and support staff. In most services, neonatal teams will also need to be involved.

Meso level

Meso-level huddles occur higher up, looking at safety and flow across and within departments. These huddles may focus on the flow of elective caesarean section lists, the number of women awaiting induction or labouring in the community, the availability of a neonatal intensive care cot for a baby with known problems, or the lack of capacity in the postnatal area to discharge women from the delivery suite.

This typically involves all teams coming together to review capacity, patient acuity and safety concerns across:

- the community (home, freestanding/alongside midwifery unit)
- fetal medicine unit
- antenatal and postnatal wards
- triage
- delivery suite
- neonatal unit.

Information gathered at micro-level huddles is collected and shared at these huddles to highlight stresses across the department.

Macro level

Macro-level huddles are operational briefings for a whole division or hospital. But they do not have to take place to achieve the benefits of meso and micro-level huddles.

Information gathered at each huddle level can be escalated from micro-level huddles all the way to macro-level huddles and vice versa for clear, transparent two-way communication throughout an organisation. The huddle's main purpose is not to resolve issues. Problem-solving requires discussion and a thorough review of all available options. This demands time and resources and detracts from the purpose of a huddle as a brief, focused, information-sharing activity.

Delivery suite team leader on using huddles for forward planning

“The huddle is a vital element of forward planning... We have a good overview of all areas and other units [from the huddle] ... It enables the MDT to minimise the risk of increased activity having a detrimental effect on safety levels...”

Top tips for implementing huddles

Maternity huddles are for improving patient flow, highlighting vulnerable patients ('watchers') to the team and ensuring safe staffing.

1. Be SMART (specific, measurable, achievable, realistic, timely) in your objectives – what outcome do you want the huddle/handover to achieve?

You need to be clear what you want to achieve in the huddle and communicate this to the team. If you are clear, it will be easier to communicate and define the 'what's in it for me?' perspective for each member of the huddle. Personal benefit promotes engagement – people will want to turn up.

2. Start small

Scale down your ambitions at the start. If you can show success at a small scale, you can convince people to broaden impact.

3. People matter

Make the key people enthusiastic. Identify who brings what information to the huddle. The people who really matter are those who will get huddles up and running. This may not be the powers at the top. Who are the key people who need to attend the huddle? You need to capture the hearts and minds of staff on the shop floor.

4. Timing is everything: keep it short and at the right time

No more than 10 to 15 minutes maximum. The shorter the better. Finding the best time for everyone can be challenging but not impossible. Once you finalise a time, set the expectation that everyone will come, and the huddle will be short. Then stick to it.

5. Standardise the process

Use a template (see Appendix 1 for examples). This keeps the structure consistent, and everyone knows what to expect and what information to share. It enables the facilitator to ensure the information shared is succinct and relevant. A checklist for each staff member may help team members bring relevant information to a huddle. Record huddle outcomes and who attended.

Ideally someone other than the facilitator should do this. Records may be used to find out whether huddles are achieving improvements.

6. Make attendance mandatory and punctual

Decide who must attend and make sure they do. Huddles are not an additional obligation; they are integral to the working day. Punctuality is a challenge to achieve but persevere – it will happen.

7. The facilitator is crucial

This will be the most difficult job. The huddle facilitator (leader/chair) will have to ensure conversations are short and relevant and yet that everyone feels heard. The facilitator needs to keep the huddle focused but maintain a broad perspective. Ownership of patient safety needs to be shared, and it will be the facilitator's job to keep this at the forefront of everyone's mind.

8. Celebrate the successes

No matter how small. This can range from shout-outs at the beginning or end of huddles to feedback on huddle outputs. For a team to own its huddle, every member must be convinced of its value.

Huddles evolve over time as you decide what works best and what information is relevant – review regularly and be flexible.

Above all, keep developing a strong team culture.

Standardising huddles and handovers

In the ever-increasing complexity of the clinical environment, embedding standardised tools, behaviours and language has been shown to improve safety.^{2,17} A shared language provides clarity and promotes the ethos of raising safety concerns. Highlighting expected behaviours and outcomes at huddles or handovers can maintain the team's focus (see Appendix 1, page 32).

Standardised approach

WHO's aide memoire on patient safety solutions¹⁷ contains tools to improve communication during handovers. The core message is that each participant should follow the same procedure and deliver the same agreed content with all unnecessary steps removed. A planned handover process is often improved by using a structured communication tool. SBAR is a commonly used approach, in which the key domains of situation, background, assessment and recommendation ensure consistency of shared information (see Appendix 2: 3.8, 3.9 and 3.10).

Similarly, huddles need a standard template for both the information brought and the information gathered there (see Appendix 1), so all members are clear about what information they must share. Huddles are not just about staffing (although they should encompass staffing and clinical workload and the resulting impact on patient flow). Patient safety issues should also be raised in huddles to improve the team's situational awareness.

Standardised time and place

When: It is important to define a start time so staff attending understand their obligations. The most usual handover time is at the start of each shift of midwives/nurses, but this may not always coincide with medical handovers. Modifying start and finish times may enable a more multiprofessional approach if the case-mix demands a multidisciplinary review, as on labour wards. Time for handover must be included in contracted hours to ensure attendance and compliance with working-time directives and job plan timetables. It should usually

be scheduled for at least 30 minutes, depending on the unit's workload and complexity. This reinforces the need for concise and consistent information sharing.

There will rarely be an ideal time for huddles, and different professional groups are likely to favour certain times based on the structure of their working day. Finding consensus can be challenging, and you may have to experiment with timing. Highlighting learning and flexibility when implementing huddles can encourage commitment as teams realise they can mould the huddle to their needs. Huddles should take place seven days a week, 365 days a year. How teams implement huddles will depend on many variables, including whether team composition varies at weekends compared to weekdays and differences in weekend working patterns. Some teams have found it easier to implement daily huddles during weekdays, to build engagement ahead of establishing huddles seven days a week.

Huddle implementation team leader on timing

“We were always clear that huddles should run seven days a week and ideally twice daily but trying to start with daily huddles was virtually impossible. There was no agreement between professional groups regarding timing during the week, and the differences in the make-up of the clinical team meant that there was even less consensus at the weekend. In the end, we decided to start running huddles during the working week to engage clinicians and rapidly show the benefits of huddles. Very soon we found that the clinical teams were driving the spread to seven days a week and actively overcoming the challenges of weekend huddles themselves.”

Where: The location of a handover or huddle is critical to its success. It needs to take place somewhere convenient for all clinical team members: too far from the clinical area may jeopardise senior team members' availability in case of an emergency, making it hard for the acute team to attend. This is particularly true for huddles requiring each team's key decision-makers to attend. Many teams have found a quiet room in or near the delivery suite to be most suitable.

Labour ward handovers often take place around the whiteboard – an asset valuable to handover but often situated in a thoroughfare, which can be vulnerable to interruptions from other staff and patients. It is important to identify a private space

or room for handover to accommodate all who attend. Ensuring the confidentiality of the information shared at handover can be challenging when it is held in an open environment: take care to ensure this is protected.

Agreed members: Participants in handovers and huddles should be defined and their attendance recorded. Handover on the antenatal or postnatal ward may be limited to a single discipline, and the other staff may be updated at later opportunities such as ward rounds. But in a labour ward, handovers should include the midwifery, obstetric and anaesthetic teams. Huddles, on the other hand, do not need the whole team to attend. Typically, obstetric, anaesthetic, neonatal and midwifery/nursing representatives from antenatal and postnatal wards, the delivery suite and neonatal unit will be necessary to scrutinise the whole patient pathway at huddles.

Trusts with multiple sites for maternity care may consider cross-site huddles. This also works where trusts are part of a clinical network with patients moving to specialist centres and supporting timely step-down transfer of care. Huddles work on the assumption that the designated huddle members' attendance is mandatory. The underlying message is that huddles are not an added obligation but an integral part of the working day.

Obstetric consultant on cross-site huddles

“Not only do we all have a bird's eye view of the clinical activity across the two sites, neonatal, midwifery, anaesthetic and obstetric, but we also have an opportunity to plan ahead and transfer early between sites, according to risk and clinical activity... It's also a very effective teambuilding exercise for staff from both sites.

Now completely embedded, the daily safety huddle allows us all to get together, as a cross-site team, and ensure truly multiprofessional working, with widespread benefits for the staff involved, but more importantly, for the care of women and babies...”

A handover's value for teaching and training is open to debate. The role of participants not directly involved in patient care is for each unit to discuss, depending on space and the handover's content. Some units use the handover to encourage debate about options for management and to review cases from the night before. This is not part of an effective handover; consider a separate forum for this.

Nominated leader/facilitator: Identify a clear handover leader. In some units this may be the delivery suite co-ordinator, in others the middle-grade doctor on call or consultant obstetrician. It is important the handover leader has an overview of **all** patients, whether high or low risk, to capture all workload and deploy staff accordingly. Some units may conduct evening handovers without the consultant present. Ideally, to promote the importance of face-to-face handovers, on-call consultants should attend the evening handover. Where this is not possible, the unit should have an agreed process for updating the on-call consultant about women in the unit who may require medical input.

The designated facilitator (leader/chair) has a crucial role not only in ensuring huddles remain focused, stick to time and cover the required scope, but in giving everyone an opportunity to speak up: engendering psychological safety within the team. Team members can change frequently, so the facilitator should start each huddle with introductions.

Avoid interruptions: Consider adopting the concept of the 'sterile cockpit' – an environment free from unnecessary distractions that enables focused, effective information sharing. Holding handovers and huddles in a quiet room, discouraging unnecessary interruptions and keeping strictly to time can help here. In some units a single person holds all the phones to avoid unnecessary calls, and the leader should discourage any conversation unrelated to the handover or huddle. Teleconferencing or video-conferencing facilities can be used for multi-site huddles. Consider what technology is available at convenient clinical locations on each site to avoid compromising attendance and timeliness.

Record output: It is important to document that a handover or huddle has taken place and who attended. You can use a simple sign-in sheet or more complex electronic tools. This will enable the team to audit performance and to ensure all team members are taking part. Communicating the result can show the inherent value of each handover/huddle and promote engagement at all levels.

Getting started

Implementation team: This should be multidisciplinary to reflect the professionals brought together. Team members will need to encourage engagement and enthusiasm as well as lead the initial implementation of huddles. Although handovers already exist in some form in most departments, implementing co-ordinated MDT handovers requires a similar approach. To make new ways of working part of daily practice, the implementation team should test and retest the new processes, act on staff feedback and widely communicate the impact on patient flow and safety. This ensures learning is documented and applied at every test cycle and keeps implementation on track.

Senior leadership: Including senior leaders is vital, particularly in huddles, to rapidly resolve safety concerns. Senior leaders (eg labour ward leads and operational managers) have the authority and resources to overcome barriers to resolving issues.

Consider a launch date: Once the preparations have been made, set a launch date so all staff are prepared and ready to engage.

Senior-level support: While there is increasing recognition that frontline clinicians must embrace and implement change for it to succeed, organisational culture can stifle such initiatives.¹⁸ The presence of senior managers (eg operational managers) at handovers and huddles not only reinforces their value but provides a forum for teams to report successes and learning. Their presence also enables non-clinical organisational issues to be rapidly addressed and resolved.

Embedding change

Structured implementation and astute use of metrics are essential to embed any service improvement. Challenges in establishing huddles and handovers will include optimising and maintaining attendance, keeping to time and achieving objectives. The first evolution of the huddle/handover will not be perfect and will not be the last. Using a structured change model is vital for sustainable change. Whether it is the model for improvement¹⁹ or Kotter's eight-step change model,²⁰ using a change management model provides a framework for implementing change with well-defined goals and quantifiable success. A structured model enables rapid

testing during implementation. Obtain continual feedback and use it to modify the huddles and handovers.

Neonatal nurse on the value of huddles

“[Huddles] promote situational awareness of where the pressure points are, prioritising staff and resources to where they are needed the most and facilitating rapid escalation to management.

Getting technology right helps buy-in... you need a common room, a common time and the right technology... we have a screen where the data goes up.

Staff have to believe there is a purpose... that they are useful. [Huddles] strengthen the bonds between wards... I don't think any of us would turn back time.”

Once implemented, the hard work begins to fully embed huddles/handovers into the organisation's culture. To embed changes into everyday life it is important to use metrics to show improvement, both for the process (of running huddles/handovers) and for its clinical benefits. Measurements of successful implementation may include achieving 100% attendance (process measure) or reducing ex-utero transfers of newborns needing neonatal care (outcome measure).

Formal and informal feedback, together with measurements, enable teams to celebrate successes and address challenges quickly so they remain engaged and 'own' their huddles/clinical handovers. Using huddles to emphasise positivity can promote staff engagement and embed huddles into culture. A quick check-in at the beginning of a huddle with all team members or a 'shout-out' about previous huddles' successful outcomes can help build a strong team culture. The check-in can also ensure all previous issues have been resolved. This will keep teams apprised of ongoing concerns as well as reinforce the huddle as a forum for addressing safety concerns early and efficiently.²¹

While effective huddles need senior clinicians – the 'decision-makers' – encouraging all team members to take part promotes awareness that huddles are for sharing information and concerns. This helps embed them in daily clinical life.

As huddles evolve, and with that, staff engagement and recognition of their value, there may be an appetite for increasing their number to meet clinical need, as well as a drive for ad hoc huddles for complex, clinically challenging situations. Continue with a structured approach to developing huddles to truly embed the changes and maintain staff commitment.

Conclusion

Good handovers and effective huddles will happen when frontline staff and healthcare organisations focused on quality recognise their value. The time may come when regulators not only require them but define them. We should use current opportunities to identify what works best in different settings. Then we should collaborate across professional boundaries to develop tools and processes that work for the whole team rather than each professional group within it, and so reduce variation.

Each trust should show it attaches value to handovers and huddles, to embed them in local practice. Education and training may be required to adopt the correct behaviours and communication techniques. Regular updates for new staff, encouraging constructive behaviours with effective feedback and discouraging disruptive behaviours will help to embed and promote effective huddles and handovers. It will take senior leadership for this to become established practice in all maternity settings, and maternity safety champions have a key role here.

Appendix 1: Sample templates and tables

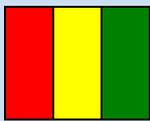
SBAR handover template

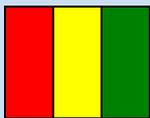
Thomas V, Dixon A (2012) Improving safety in maternity services. A toolkit for teams. The King's Fund.

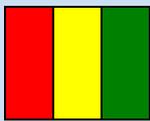
https://www.kingsfund.org.uk/sites/default/files/field/field_related_document/Improving-safety-in-maternity-services-communication1.pdf

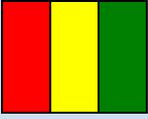
Crib sheets for staff

Below are sample crib sheets that lead areas can use to bring key information to huddles. You can adapt them to make them relevant to your huddle. Also consider including information about clinical activity and safety concerns in triage, day assessment unit, standalone birth centres and home births.

Delivery Suite		Date		
Total number of beds				
Patient acuity	Antenatal			
	In labour			
	Postnatal			
Available	Beds			
Expected admissions	Elective CS			
	Inductions			
High risk (details)				
*high risk= <37/40; <2kg; antenatally diagnosed issues				
Anticipated in utero transfers	In			
	Out			
Anticipated discharges				
Staffing 	Midwifery	Day	Midwives	MSWs
		Night	Midwives	MSWs
	Medical	Day		
		Night		
Safe to start?				
Situational awareness				

Birth centre			Date	
Total number of beds				
Patient acuity	In labour			
	Postnatal			
Available	Beds			
Anticipated discharges				
Staffing 	Midwifery	Day	Midwives	MSWs
		Night	Midwives	MSWs
Safe to start? 				
Situational awareness				

Postnatal			Date	
Total number of beds				
Patient acuity	Antenatal			
	In labour			
	Postnatal			
Available	Beds			
Expected admissions	Elective CS			
	Inductions			
High risk (details)				
*high risk= <37/40; <2kg; antenatally diagnosed issues				
Anticipated in utero transfers	In			
	Out			
Anticipated discharges				
Staffing 	Midwifery	Day	Midwives	MSWs
		Night	Midwives	MSWs
	Medical	Day		
		Night		
Safe to start?				
				
Situational awareness				

Neonatal unit		Date	
Total number of beds			
Patient acuity	ITU		
	HDU		
	SCBU		
Available	Beds		
NNU cots open?	Internal		
	External		
Expected ex utero transfers	In		
	Out		
Anticipated discharges			
Watchers			
Staffing 	Nursing	Day	
		Night	
	Medical	Day	
		Night	
Safe to start?			
Situational awareness			

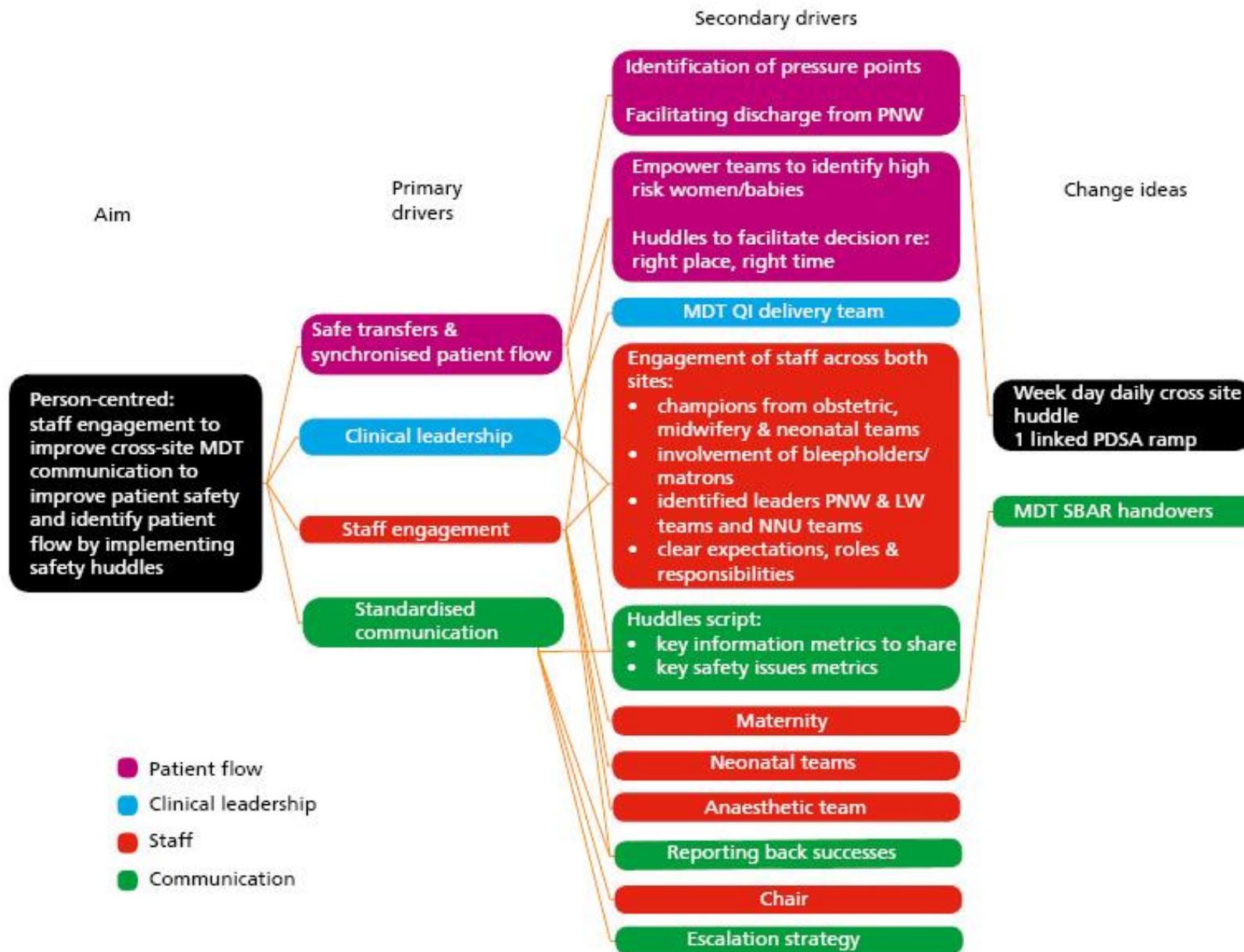
Huddle monitoring/feedback tool: When introducing maternity huddles, it is important to be able to measure both the process of implementation and staff perception of the value of huddles and impact on their working day. The change team implementing huddles can use this tool during the testing phase. It may be more appropriate to administer the process questions daily during the testing phase and the staff perception aspect intervals during implementation. Regular feedback of the findings of the monitoring tools will ensure staff remain engaged.

(Adapted from the Iowa Health Systems Safety Huddles results survey)

Questions asked at huddles	Date	Date	Date	Date	Date	Totals
Start time						
Finish time						
Duration of meeting in minutes?						
Attendance						
Staff present						
Obstetric consultant						
DS co-ordinator						
Maternity bleep-holder						
NNU consultant						
NNU nurse in charge						
PNW charge midwife						
Anaesthetic consultant						
Were the right people there? If not, who else should attend?						
Record of huddle kept? Y/N						

Questions asked on AM survey	Date	Date	Date	Date	Date	Totals
Surveys (show of hands)						
On a scale of 1 to 5, how useful do you think the safety briefing/huddle will be in helping to reduce the risk of device-use errors? 1 Not Useful → 3 Neutral → 5 Very Useful						
On a scale of 1 to 10, how valuable do you think this will be in improving the quality of care? 1 Not Valuable → 3 Neutral → 5 Very Valuable						
Would you recommend that the sessions continue? Yes/No						

Sample driver diagram (see next page): A driver diagram is a powerful tool that helps you translate the overall improvement aim into a logical set of key ‘drivers’ that contribute to the project aim (eg improving MDT communication and situational awareness) and how you can achieve it through change ideas (structured clinical handovers/huddles). It provides a clear image of the team’s shared vision.



Sample output proforma: It is important to document the output of huddles and share it with the wider senior team. Senior managers can use this output for a rapid overview of the pressure points across the maternity service and mobilise resources appropriately.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	
1	MATERNITY S			DATE			TIME							Midwifery staffing		Medical staffing		SAFE TO START	SITUATIONAL AWARENESS						
2				PATIENT ACUITY			AVAILABLE		ADMISSIONS		high risk deliveries * (no.)	High risk delivery: details	IN-UTERO TRANSFERS		Anticipated D/CHARGES	RAG		RAG		SAFE TO START	SITUATIONAL AWARENESS				
3	Site	WARD	BEDS	Antenatal	In labour	Postnatal	BEDS	CUBS	Inductions	El.CS				IN	OUT		Day	Night	Day	Night	RAG				
4	site 1	DS																							
5		postnatal																							
6																									
7	site 2	DS																							
8		postnatal																							
9																									
10				ACUITY			AVAILABLE		NNU cots open?		Watchers: details		EX-UTERO		Anticipated D/CHARGES	Nurse staffing		Medical staffing		SAFE TO START (RAG)	SITUATIONAL AWARENESS				
11	Site	WARD	BEDS	ITU	HDU	SCBU	BEDS	side rooms	Internal	external				IN	OUT		Day	Night	Day	Night	SAFE TO START (RAG)	SITUATIONAL AWARENESS			
12	site 1	SCBU																							
13	site 2	NICU																							
14																									
15	Issues																								
16	Staffing																								
17	Incidents																								
18																									
19	<i>*high risk= <37/40; <2kg; antenatally diagnosed issues</i>																								

Multi-professional hand-overs on Labour ward (including 'board rounds' & 'ward rounds')

KEY POINTS:

- ❖ At the start of the handover, all team members should introduce themselves and clarify their roles for that shift:
 - *Medical staff to write name and bleep number on bleep board outside staff room*
- ❖ Ensure interruptions are kept to minimum by:
 - *'Hand-over in progress' sign to be displayed on Room 10 door*
 - *M/W Coordinator to give drug cupboard keys to outside staff and write on the 'Hand-over in progress' sign, the name of the member of staff who has the keys*
 - *Staff should only be called out of the ward round if there is an emergency*
 - *Keep the ward round as short as possible*
- ❖ Nurture an open environment where all professional comments are welcome:
 - *No drinks or breakfast to be consumed during any handover*
- ❖ The 08.00 and 20.00 hand-over should be led by the M/W coordinator and the obstetric registrar going off shift
- ❖ Encourage SBAR style communication:
(Situation, Background, Assessment and Recommendation)
- ❖ Hand-overs should include women that require review on Quantock, QAU and on postnatal wards and discussion of elective theatre cases (before doing walk-round review on Labour ward).
- ❖ At the end of hand-over, formulate action plans and task allocation in priority order:
 - *Action (e.g. FBS, review by labour ward team)*
 - *Person (e.g. Dr Smith, labour ward team)*
 - *Priority (e.g. 1st)*

NB. The Labour ward team should also conduct a 'ward round' to review all women on labour ward with complications, documenting a plan of care in their maternity notes. If women are requiring Critical Care, then the Maternal Critical Care Structured Review pro forma should be completed.

- ❖ The team should work together to ensure that actions are completed in a timely manner and labour ward runs efficiently.
- ❖ Consider running debrief sessions after hand-over with any of the team going off shift:
 - *Discuss the team management of difficult cases*
 - *This can be an additional feedback opportunity*
- ❖ There should be a telephone hand-over between the on-call obstetric consultant and the obstetric registrar at 10.00pm and also at 5pm if consultant is not present on labour ward.

Appendix 2: Resources

1. NHS Scotland Quality Improvement Hub

- 1.1. Whole-system flow improvement [website](#)
- 1.2. Yorkhill 8am safety huddle video
<http://www.qihub.scot.nhs.uk/video-hub/yorkhill-huddle.aspx>
- 1.3. Hospital safety flow huddle guidance document
http://www.qihub.scot.nhs.uk/media/864807/huddles%20guidance%20document_ed.pdf

2. Institute for Healthcare Improvement resources

- 2.1. Tools: plan-do-study-act worksheet
<http://www.ihl.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx>
- 2.2. Tools: huddles
<http://www.ihl.org/resources/Pages/Tools/Huddles.aspx>
- 2.3. Tools: SBAR tool (Situation-Background-Assessment-Recommendation)
<http://www.ihl.org/resources/Pages/Tools/SBARToolkit.aspx>
- 2.4. Changes: real-time demand/capacity management
<http://www.ihl.org/resources/Pages/Changes/RealTimeDemandCapacityManagement.aspx>
- 2.5. Changes: use regular huddles and staff meetings to plan production and optimise team communication
<http://www.ihl.org/resources/Pages/Changes/UseRegularHuddlesandStaffMeetingstoPlanProductionandtoOptimizeTeamCommunication.aspx>

3. Other resources

- 3.1. Bergstol J, Kratzer R, Lubinensky M (February 2015) Huddle up for patient safety. *American Nurse Today* 10 (2): 1-6.
- 3.2. Avoiding term admission into neonatal units (ATAIN) programme: e-learning resource, 2017
<https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/>

- 3.3. Royal College of Midwives: labour ward leaders workshops
<https://www.rcm.org.uk/get-involved/events/labour-ward-leaders-workshop-1>
- 3.4. Royal College of Obstetricians and Gynaecologists: improving human factors and situational awareness toolkit.
<https://www.rcog.org.uk/en/guidelines-research-services/audit-quality-improvement/each-baby-counts/implementation/improving-human-factors/video-briefing/>
- 3.5. Civil Aviation Authority: flight crew human factor handbook
publicapps.caa.co.uk/cap737
- 3.6. Helping people to speak up in maternity
<https://improvement.nhs.uk/resources/listen-to-me-helping-people-speak-up-in-maternity/>
- 3.7. Royal College of Physicians: acute care toolkit – handover
<https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-1-handover>
- 3.8. NHS Improvement: guide to SBAR
<https://improvement.nhs.uk/resources/sbar-communication-tool/>
- 3.9. Using the SBAR tool
<http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/T4I%20%283%29%20SBAR.pdf>
- 3.10. Tool to help with safe communication
<https://www.england.nhs.uk/signuptosafety/wp-content/uploads/sites/16/2015/09/safe-comms-design-implmnt-meas.pdf>

Appendix 3: Members of the working group

The framework was developed with involvement from all professional groups whose members contribute to providing maternity care. Members of the working group were:

Lead authors:

- Dr Shanthy Shanmugalingam, Consultant Neonatologist, Royal Free London NHS Foundation Trust
- Dr Sheila Macphail, Consultant Obstetrician (retired) and member of Royal College of Obstetricians and Gynaecologists (RCOG) quality and safety committee (Chair)

Paul Davis, former Air Accident Investigator

Dr Cora Doherty, Consultant Neonatologist and representative of British Association of Perinatal Medicine

Mandy Forrester, Head of Quality and Standards, Royal College of Midwives

Dr Kate Harding, Consultant Obstetrician and representative of RCOG

Dr Megan Smith, Consultant Anaesthetist, Royal Free London NHS Foundation Trust

Mara Tonks, Lead Midwife, Kettering General Hospital. Lead for the 'Listen to Me' campaign

Michele Upton, Lead for the ATAIN programme, Head of Maternity and Neonatal Transformation Programmes, NHS Improvement

Professor Jimmy Walker, Clinical Advisor on Maternity and Gynaecology to the Care Quality Commission

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Contact us:

NHS Improvement

Wellington House
133-155 Waterloo Road
London
SE1 8UG

0300 123 2257

enquiries@improvement.nhs.uk
improvement.nhs.uk

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