Healthcare Improvement Scotland

SCOTTISH PATIENT SAFETY PROGRAMME

Perinatal and paediatric approach to Essentials of Safe Care

SPSP Perinatal and SPSP Paediatric Programmes

Leading quality health and care for Scotland

NHS SCOTLAND

Welcome

Jacqui Laurie

Strategic National Clinical Lead for Obstetrics

Healthcare Improvement Scotland

Housekeeping – virtual delegates

- **Cameras and microphones** are disabled by default
- **Questions:** Use the chat to ask questions for our speakers
- **Technical issues:** Use the chat or email his.spsppp@nhs.scot
- **Recording:** The first part of the session is being recorded

Breakout session agenda

Time	Topic	Lead
13:35	Welcome, introductions and scene setting	**Jacqui Laurie** Strategic National Clinical Lead for Obstetrics, Healthcare Improvement Scotland
13:40	Perinatal presentation	**Augusta Anenih** Consultant Neonatologist, NHS Lanarkshire
14:00	Q&A with the perinatal speaker	**Jacqui Laurie**
14:05	Paediatric scene setting	**Donna Frew** Senior Improvement Advisor, Healthcare Improvement Scotland
14:10	Paediatric presentation	**Neil Fiddes** Staff Nurse, NHS Highland
14:30	Q&A with the paediatric speaker	**Jacqui Laurie**
14:35	Comfort break	
14:50	Group discussion	**Damian Boyd** Improvement Advisor, Healthcare Improvement Scotland
15:30	Closing remarks	**Jacqui Laurie**

Aims of the breakout

- Understand family-integrated approaches to reducing term admissions
- Explore family inclusion in the care of deteriorating children and young people
- Provide opportunities for group discussion and networking with colleagues across Scotland (for in-person attendees only)

Who’s here, online and in the room?

Scottish Patient Safety Programme (SPSP)

SPSP aims to improve the safety and reliability of care and reduce harm

Core themes

- **Essentials of Safe Care**
- **SPSP Programme improvement focus Perinatal, Paediatric, Adults in Hospital and Mental Health**
- **SPSP Learning System**

Key changes

Our Vision	The delivery of safe care, improving outcomes for every person, every time across health and care
New Focus	People Led, Inequalities, Clinical and Care Governance, Digital
Change at each level	Change Ideas developed at practitioner, service and organisational level
Readiness for change	Readiness for change assessment aligned to the Scottish Approach to Change

Essentials of Safe Care 2025

EoSC

Readiness Tool

Our vision is	Delivered through ...	Which requires...
The delivery of safe care, improving outcomes for every person, every time across health and care	A people-led approach to the planning and delivery of safe care	People and professionals are equal partners in shared decision making Care and support is shaped to meet the needs of people People, families, carers and staff are systematically listened to, and concerns are acted upon
	Effective and inclusive communication	Communication tailored to individual needs and preferences People and teams feel safe and able to speak up Team communication and collaboration
	Leadership at all levels to support a culture of safety	Leadership is compassionate and inclusive Staff feel supported and valued Learning system for continuous improvement Everyone has the opportunity to learn and develop
	Safe clinical and care processes	Safe staffing and skill mix Care is up to date and evidence based Clinical and care governance structures support safety Information systems that work together

SPSP Perinatal Programme

SPSP Perinatal aims to improve outcomes for women, birthing people, babies and families across Scotland

SPSP Perinatal

SPSP Essentials of Safe Care

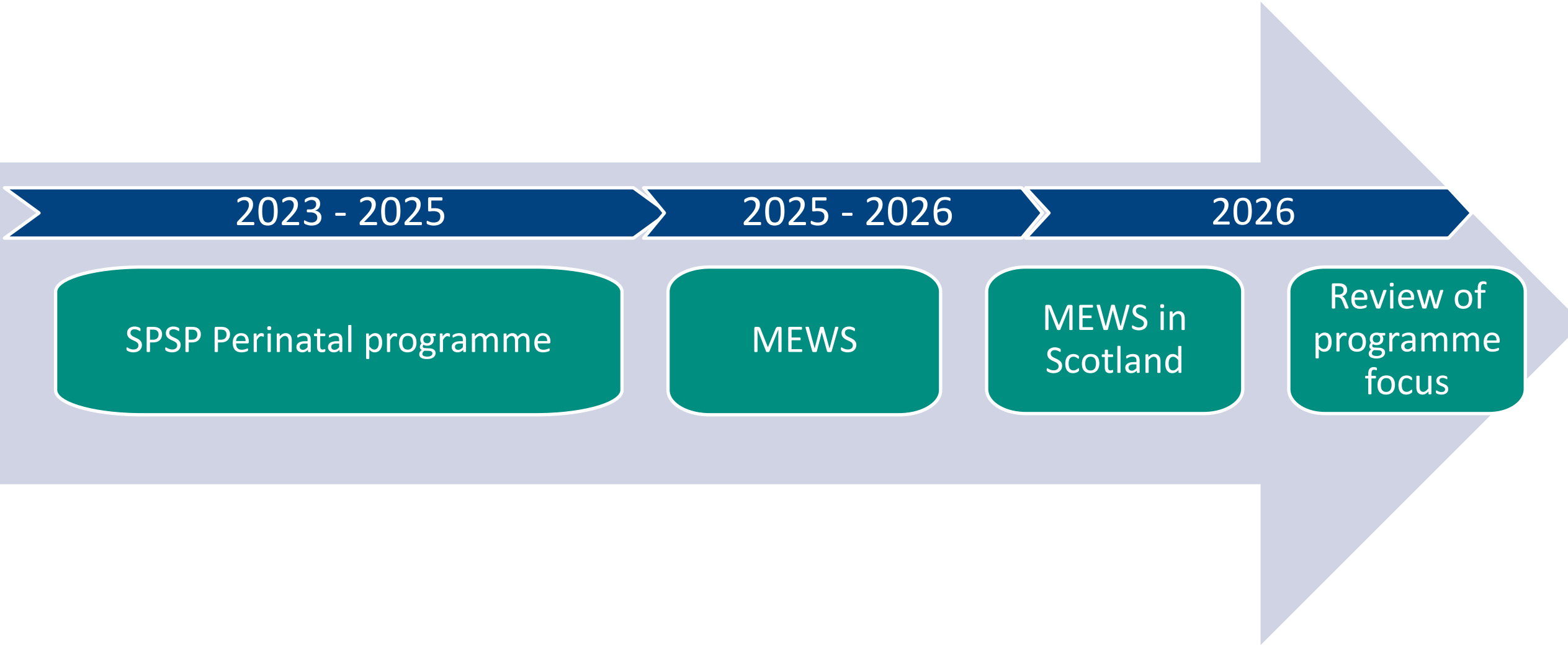
Current focus

Stillbirth | Neonatal morbidity and mortality

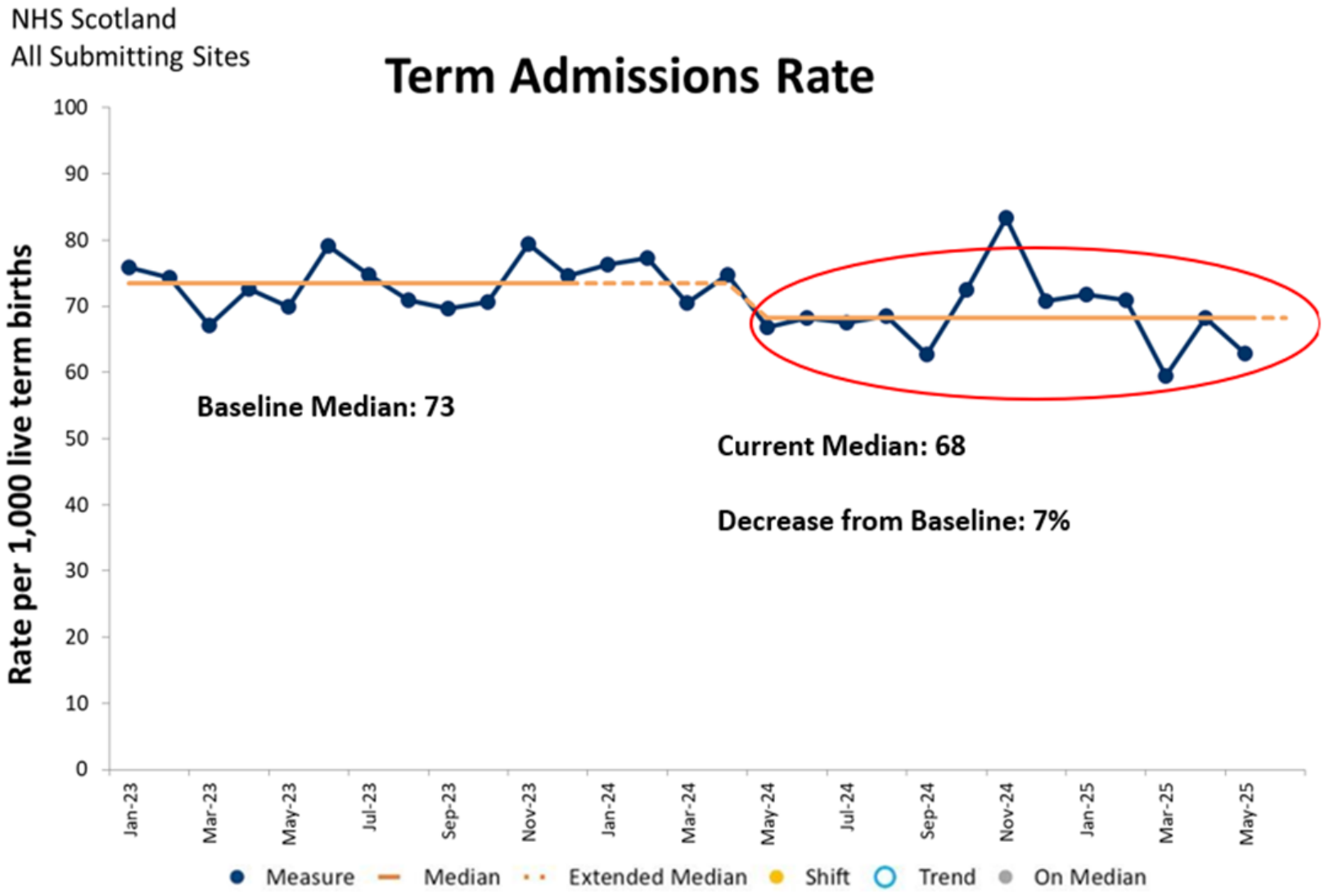
Maternal deterioration | Caesarean birth

Learning System

SPSP Perinatal



Collaborative activity

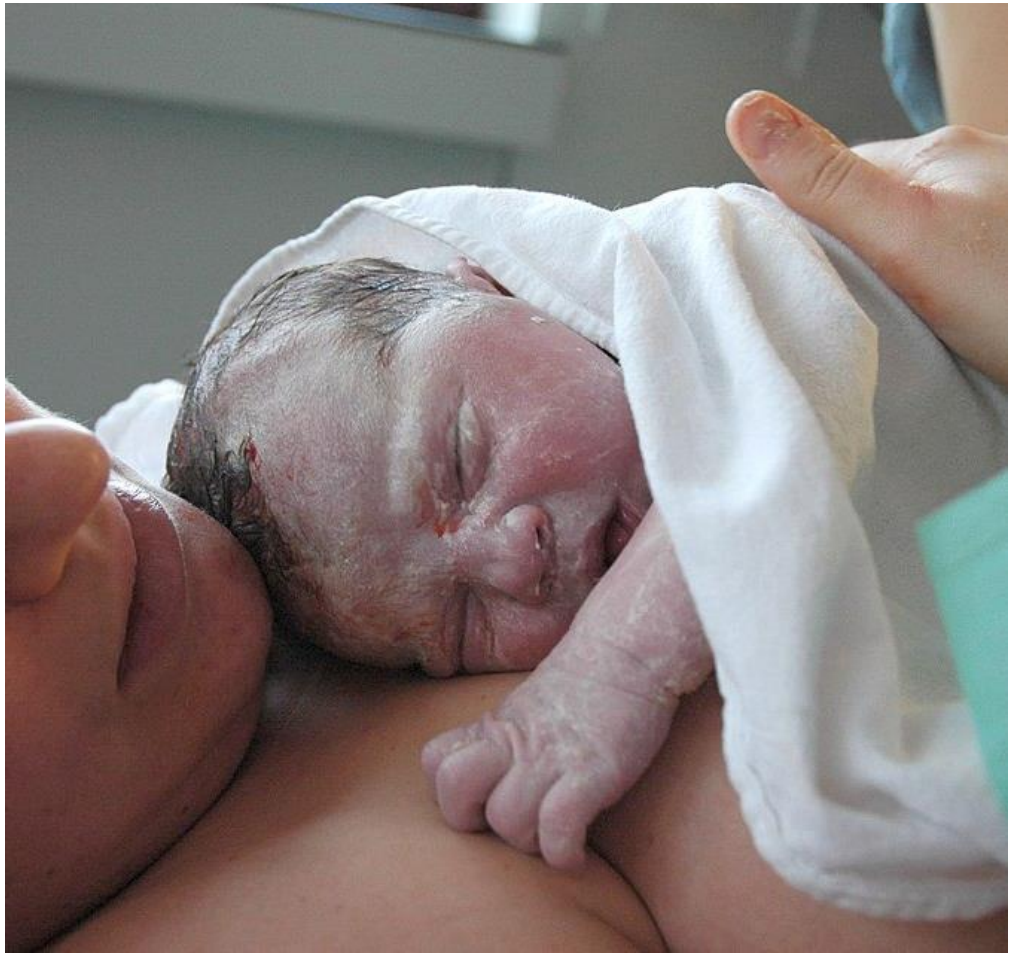


Keeping Families Together

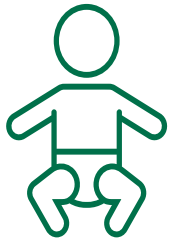
Reducing Unplanned Term Admissions in NHS Lanarkshire Through Perinatal Collaboration & Patient Centred Care

Augusta Anenih
Consultant Neonatologist
NHS Lanarkshire
Scottish Quality & Safety Fellow

“Every unplanned admission is more than a bed space — it’s a family separation we can prevent.”



Why it Matters



Baby

- ↑ stress physiology
- Poorer self-regulation
- Reduced breastfeeding
- Neurodevelopment risk

Mother

- Reduced bonding
- Higher stress/anxiety
- Lower maternal competence
- Impact on maternal health outcome

Staff

- Increased complexity
- Emotional burden
- Missed opportunities for best practice
- Lower staff satisfaction

Unit

- Higher resource use
- Compromised quality of care
- Poorer family experience
- Cultural or operational challenges

Population

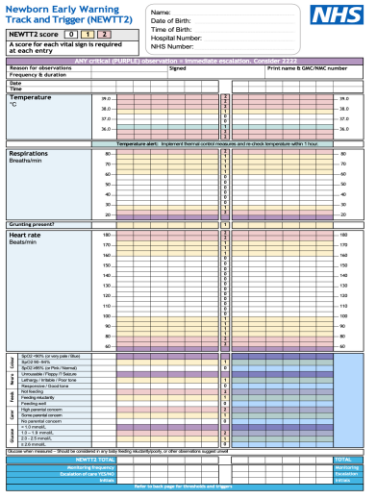
- Public health impact (worse outcomes, higher costs)
- Equity
- Entrenched culture of separation vs togetherness

We realised many admissions were NOT about acuity — rather about systems, processes, collaboration and absence of innovative use of EBM.

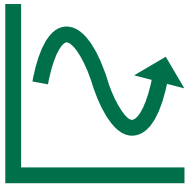
Our Aim

Perinatal Collaboration

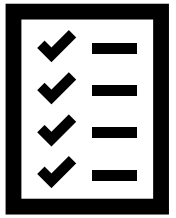
Early Recognition and Escalation



Reduce avoidable term neonatal admissions, whilst keeping mothers and babies together safely



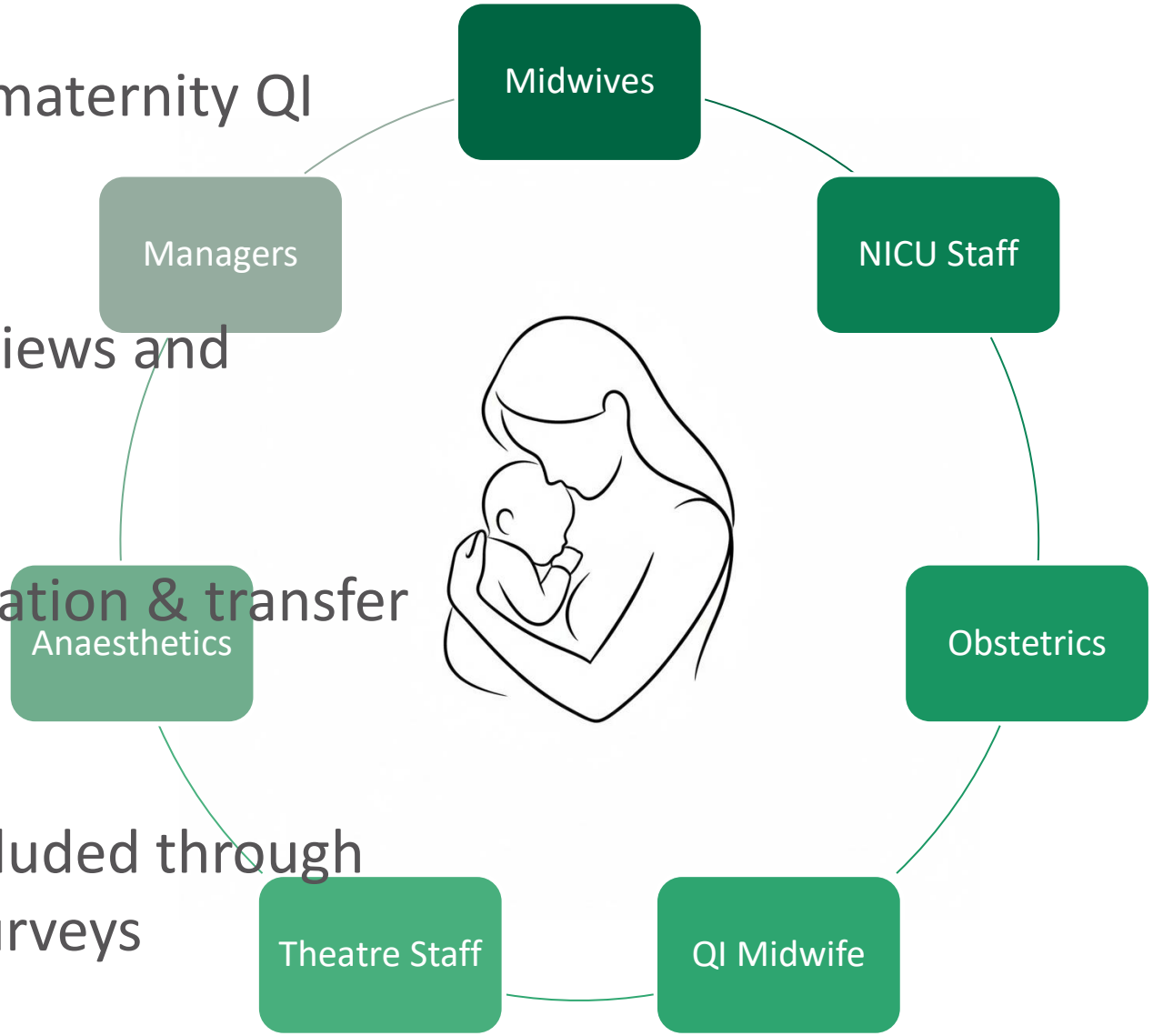
Data-driven Improvement and Continuous Learning



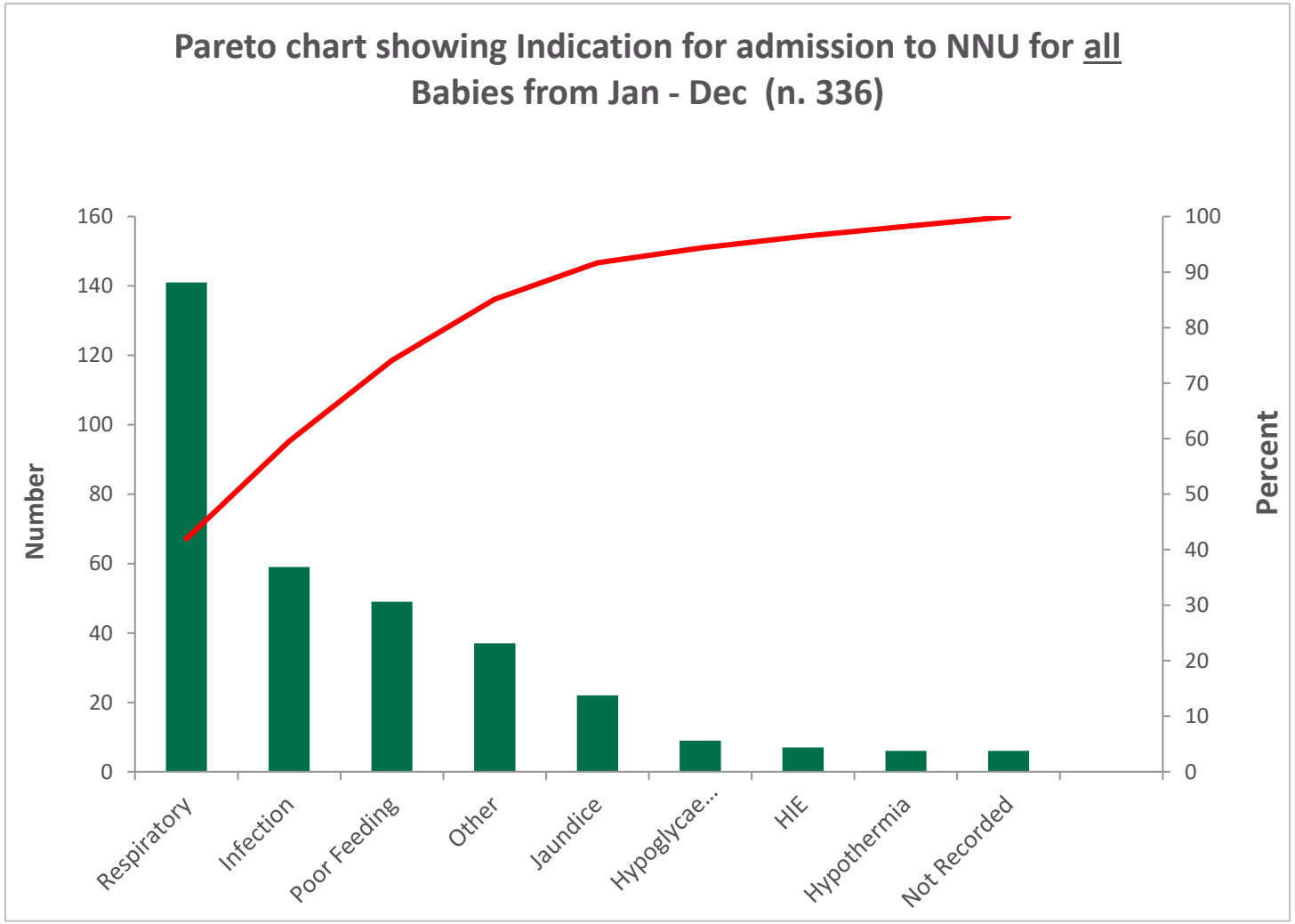
Risk Assessment, Safe Triage and Decision Making

Collaboration and Culture

- Joint neonatal–maternity QI group formed
- Weekly case reviews and shared data
- Integrated escalation & transfer pathway
- Family voice included through feedback and surveys

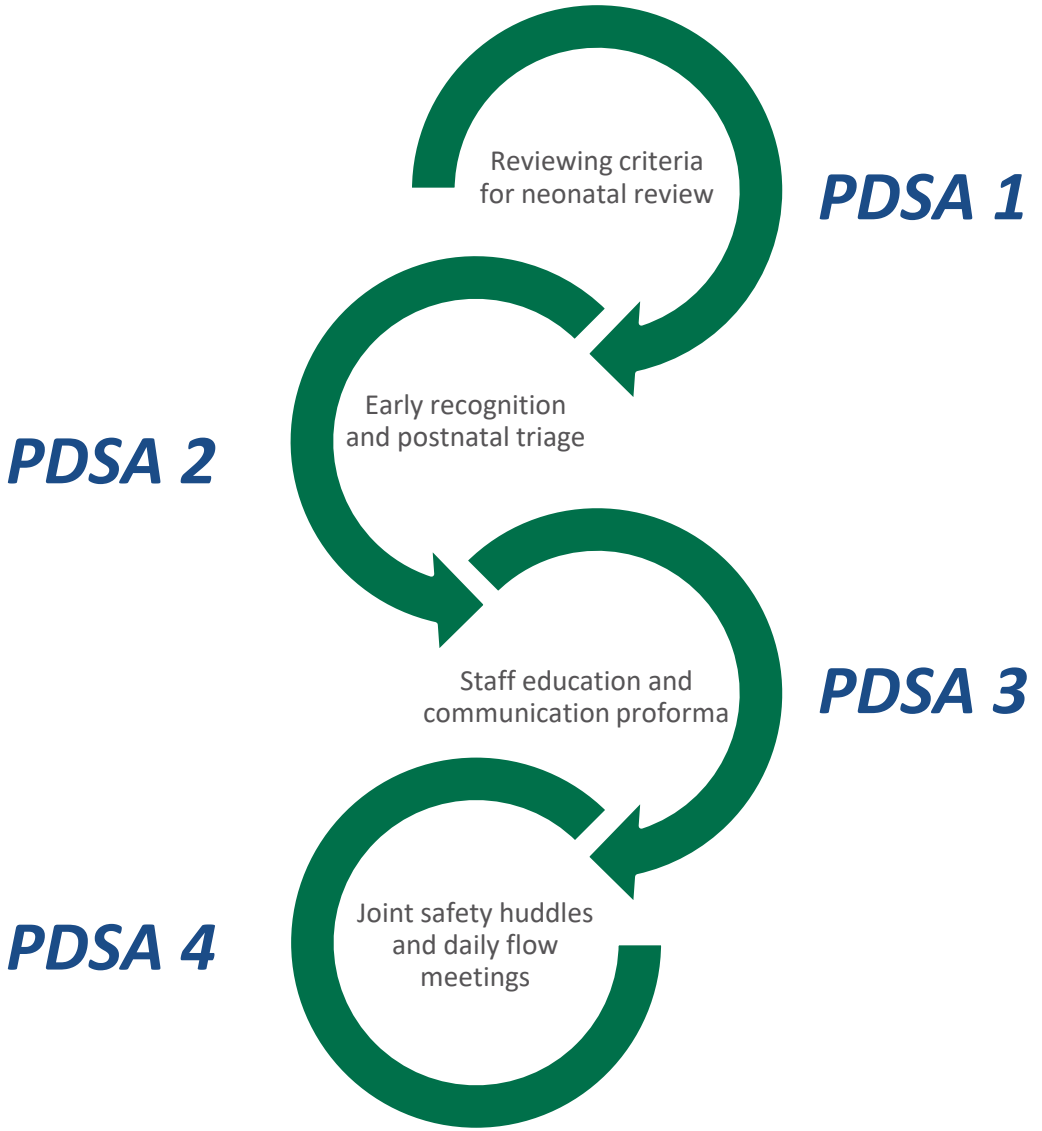


Understanding our System



- Variation
  - Practices, escalation
- Silo working
- Culture
- Staff anxiety
- Parental anxiety
- Documentation gaps

Quality Improvement in Action



We learned to test small, fail fast, and learn forward.

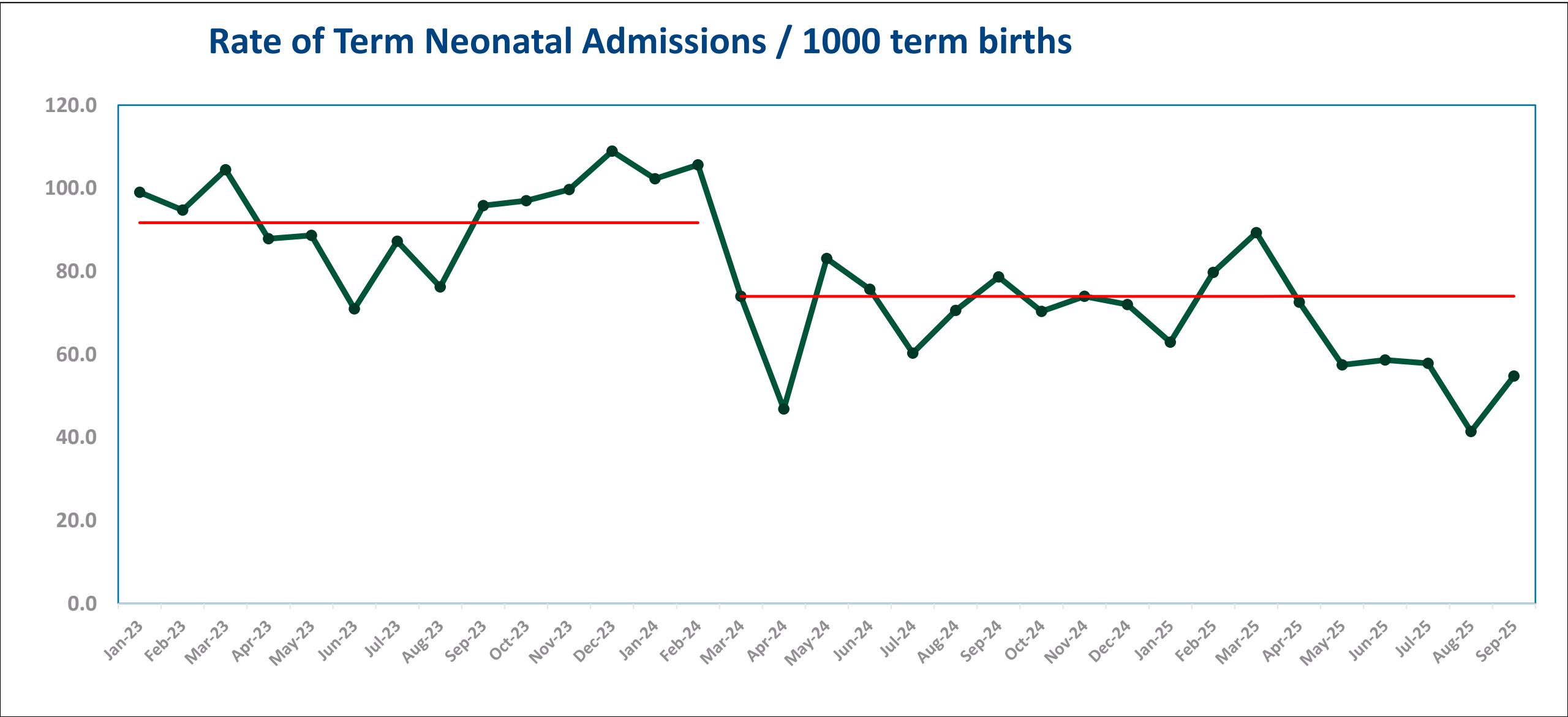
Patient-centred care

- Family-integrated care pathways for term neonates.
- Parent-infant togetherness prioritised in every decision.
- Patient stories used as feedback loops in QI cycles.

KEEPING ♡ FAMILIES TOGETHER

Keeping families together isn't just kind — it's clinically effective.

Our outcome


Rate of Term Neonatal Admissions / 1000 term births
120.0
100.0
80.0
60.0
40.0
20.0
0.0
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
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Our outcomes

- 40% reduction in unplanned term admissions
- Increased maternal satisfaction & experience
- Improved breastfeeding initiation rates
- Optimised patient flow and cot availability
- Positive staff engagement and morale

Our data tells a story — fewer separations, better starts.

Lessons learned

Essentials of Safe Care:
Keeping Mothers and Babies Together

Person Centred & family centred care	➢ Prioritise mother-baby togetherness as the default ➢ Enable continuous skin-to-skin and rooming in ➢ Involve parents in decision making and escalation
Workforce capability & collaboration	➢ Train midwives, neonatal, and obstetric teams in joint stabilization at the bedside ➢ Cross-skill teams to manage mild neonatal concerns on postnatal wards ➢ Use shared handovers between maternity and neonatal teams
Learning from data & outcomes	➢ Reviewing unplanned term admissions through governance pathways ➢ Track causes (e.g. respiratory hypoglycemia, jaundice) and identify avoidable patterns ➢ Share data transparently with staff for continuous learning
Safe systems & processes	➢ Implement clear escalation pathways to support care with the mother ➢ Standardise care bundles for common issues – skin-to-skin, thermoregulation, antibiotic guardianship ➢ Use early warning tools for mother and baby
Compassionate, inclusive culture	➢ Create a 'Together is Best' cultures - separation only if clinically essential ➢ Support staff emotional wellbeing when separations occur ➢ Celebrate successes in keeping families together
Continuous improvement & leadership	➢ Establish a multidisciplinary improvement group ➢ Use PDSA cycles to test new processes ➢ Share learning regionally

Thank you

NHS Lanarkshire

Together, we are building safer, kinder systems

UNIVERSITY HOSPITAL WISHAW
NEONATAL UNIT