



Healthcare
Improvement
Scotland



Perinatal and paediatric approach to Essentials of Safe Care

SPSP Perinatal and SPSP Paediatric Programmes

Leading quality health and care for 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

Effective and inclusive
communication

Leadership at all levels
to support a
culture of safety

Safe clinical and care
processes

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

Communication tailored to individual needs and preferences

People and teams feel safe and able to speak up

Team communication and collaboration

Leadership is compassionate and inclusive

Staff feel supported and valued

Learning system for continuous improvement

Everyone has the opportunity to learn and develop

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

2023 - 2025

SPSP Perinatal programme

2025 - 2026

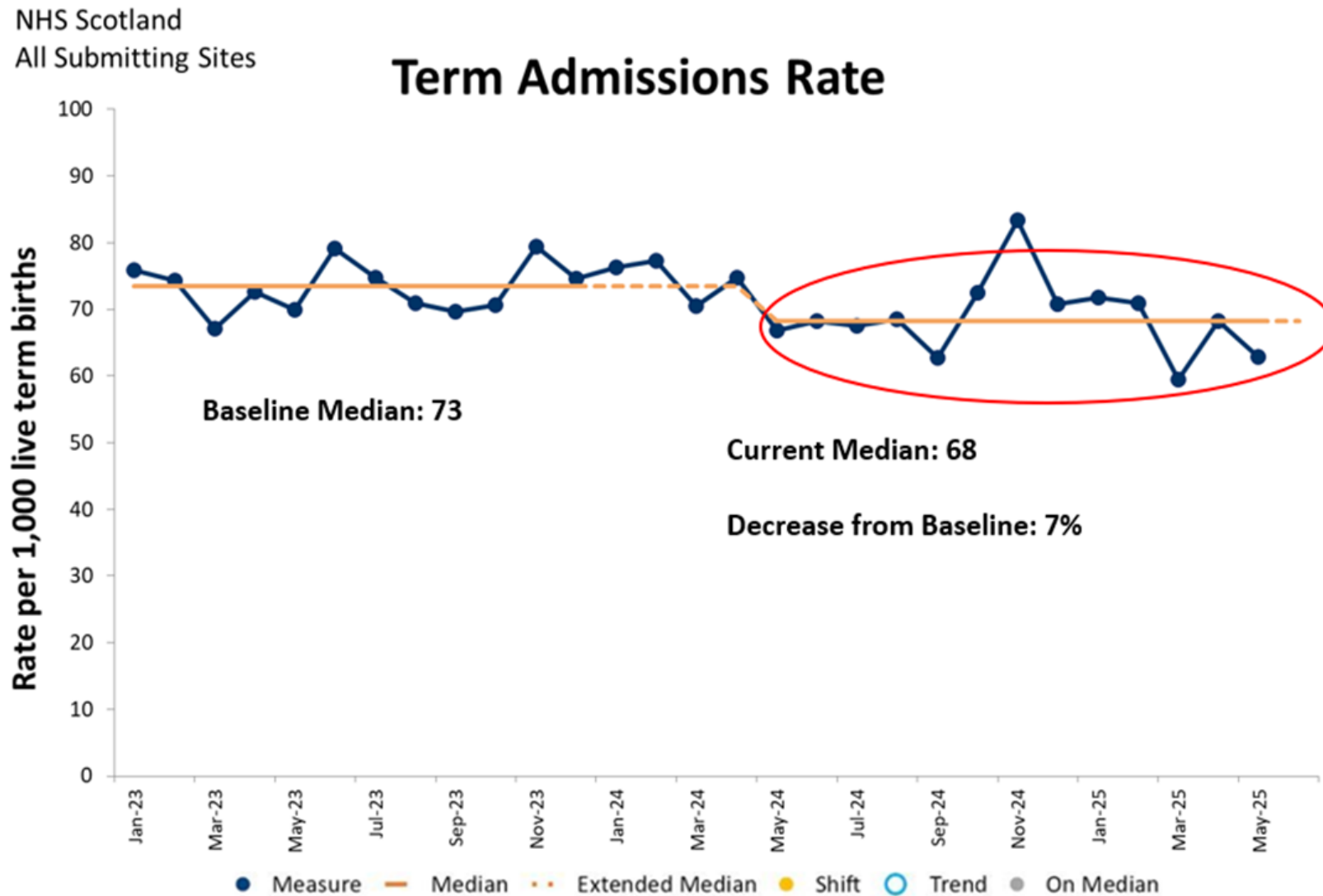
MEWS

2026

MEWS in
Scotland

Review of
programme
focus

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

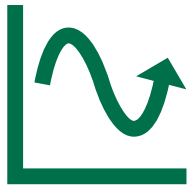
***We realised many admissions were
NOT about acuity — rather about
systems, processes, collaboration
and absence of innovative use of
EBM.***

Our Aim

Perinatal Collaboration



Data-driven Improvement and Continuous Learning

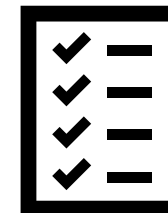


**Reduce avoidable term
neonatal admissions,
whilst keeping mothers
and babies together safely**

Early Recognition and Escalation

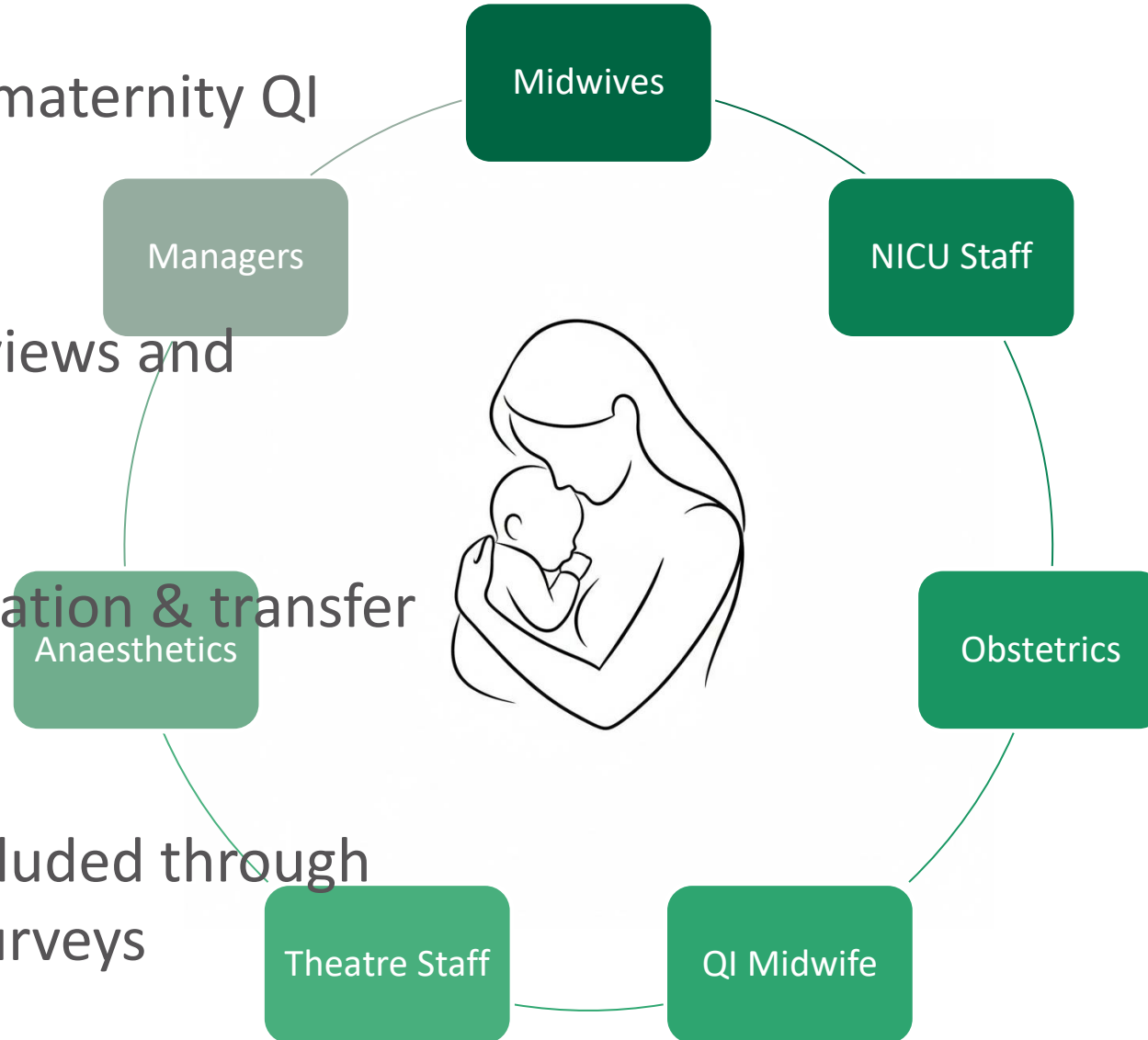
Newborn Early Warning Track and Trigger (NEWT2)			Name: _____ Date of Birth: _____ Time of Birth: _____ Hospital Number: _____ NHS Number: _____			
NEWT2 score 0 1 2						
2 score for each vital sign is required at each entry						
Parent for observations Emergency & Address: _____			Urgent		Print name & GMC/NIH number	
Respiratory & Circulation						
Rate			Temp		SpO2	
Temperature			SpO2		SpO2	
36.0 - 37.5			36.0 - 37.5		94.0 - 98.0	
37.5 - 40.0			37.5 - 40.0		94.0 - 98.0	
40.0 - 42.0			40.0 - 42.0		94.0 - 98.0	
Respirations			SpO2		SpO2	
30 - 60			30 - 60		94.0 - 98.0	
60 - 90			60 - 90		94.0 - 98.0	
90 - 120			90 - 120		94.0 - 98.0	
120 - 150			120 - 150		94.0 - 98.0	
150 - 180			150 - 180		94.0 - 98.0	
180 - 210			180 - 210		94.0 - 98.0	
210 - 240			210 - 240		94.0 - 98.0	
240 - 270			240 - 270		94.0 - 98.0	
270 - 300			270 - 300		94.0 - 98.0	
300 - 330			300 - 330		94.0 - 98.0	
330 - 360			330 - 360		94.0 - 98.0	
360 - 390			360 - 390		94.0 - 98.0	
390 - 420			390 - 420		94.0 - 98.0	
420 - 450			420 - 450		94.0 - 98.0	
450 - 480			450 - 480		94.0 - 98.0	
480 - 510			480 - 510		94.0 - 98.0	
510 - 540			510 - 540		94.0 - 98.0	
540 - 570			540 - 570		94.0 - 98.0	
570 - 600			570 - 600		94.0 - 98.0	
600 - 630			600 - 630		94.0 - 98.0	
630 - 660			630 - 660		94.0 - 98.0	
660 - 690			660 - 690		94.0 - 98.0	
690 - 720			690 - 720		94.0 - 98.0	
720 - 750			720 - 750		94.0 - 98.0	
750 - 780			750 - 780		94.0 - 98.0	
780 - 810			780 - 810		94.0 - 98.0	
810 - 840			810 - 840		94.0 - 98.0	
840 - 870			840 - 870		94.0 - 98.0	
870 - 900			870 - 900		94.0 - 98.0	
900 - 930			900 - 930		94.0 - 98.0	
930 - 960			930 - 960		94.0 - 98.0	
960 - 990			960 - 990		94.0 - 98.0	
990 - 1020			990 - 1020		94.0 - 98.0	
1020 - 1050			1020 - 1050		94.0 - 98.0	
1050 - 1080			1050 - 1080		94.0 - 98.0	
1080 - 1110			1080 - 1110		94.0 - 98.0	
1110 - 1140			1110 - 1140		94.0 - 98.0	
1140 - 1170			1140 - 1170		94.0 - 98.0	
1170 - 1200			1170 - 1200		94.0 - 98.0	
1200 - 1230			1200 - 1230		94.0 - 98.0	
1230 - 1260			1230 - 1260		94.0 - 98.0	
1260 - 1290			1260 - 1290		94.0 - 98.0	
1290 - 1320			1290 - 1320		94.0 - 98.0	
1320 - 1350			1320 - 1350			

Risk Assessment, Safe Triage and Decision Making

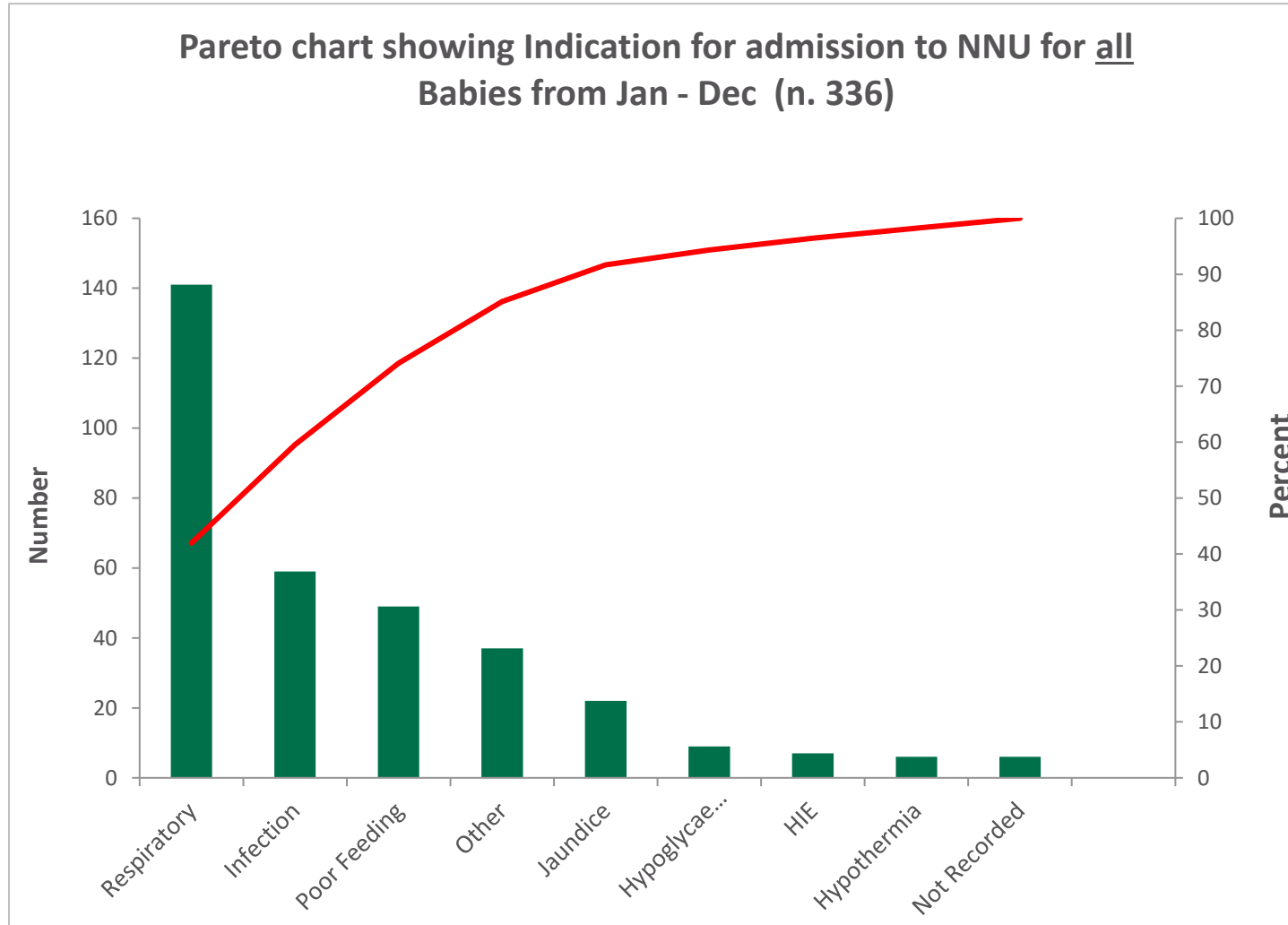


Collaboration and Culture

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

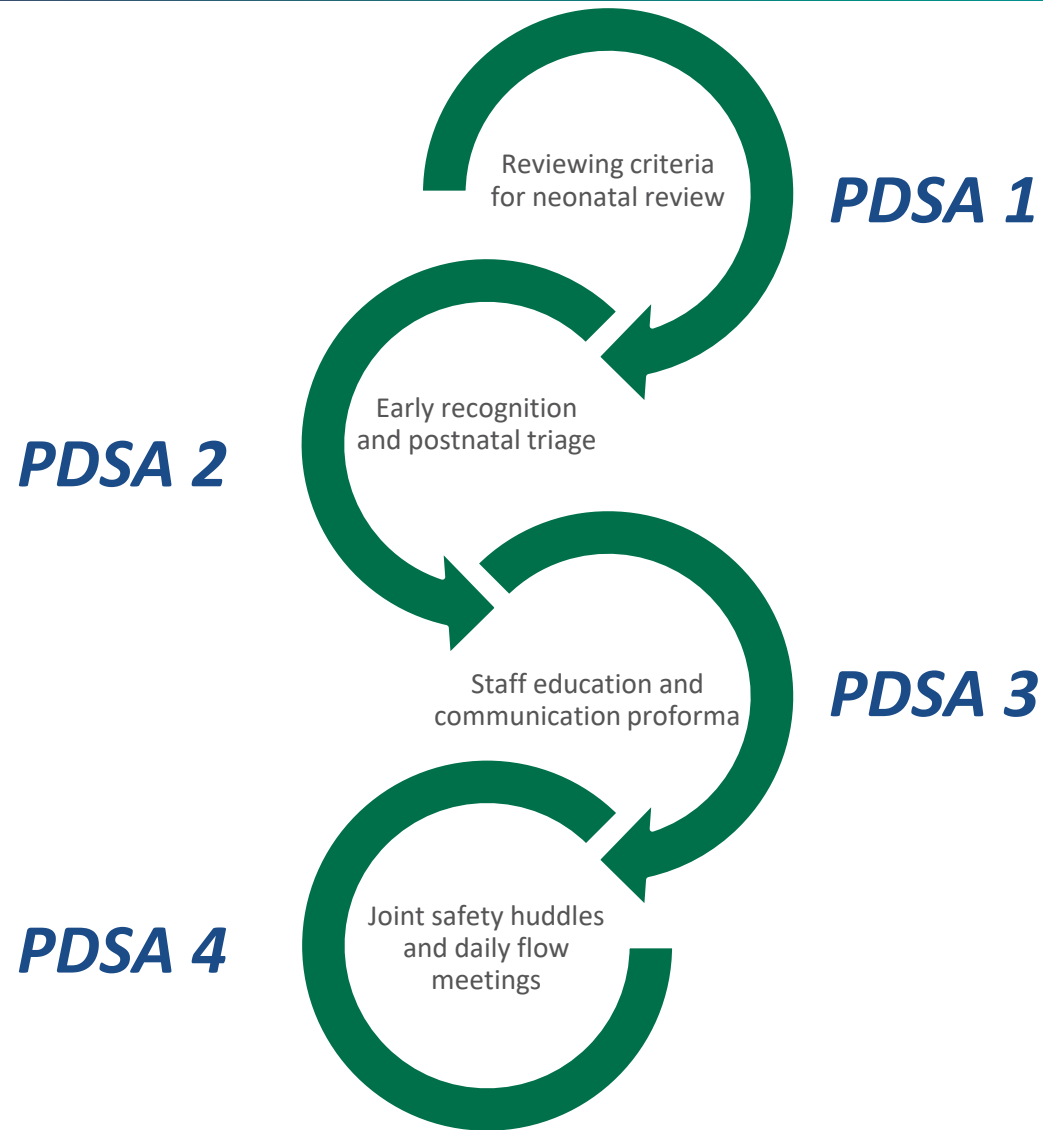


Understanding our System



- 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.

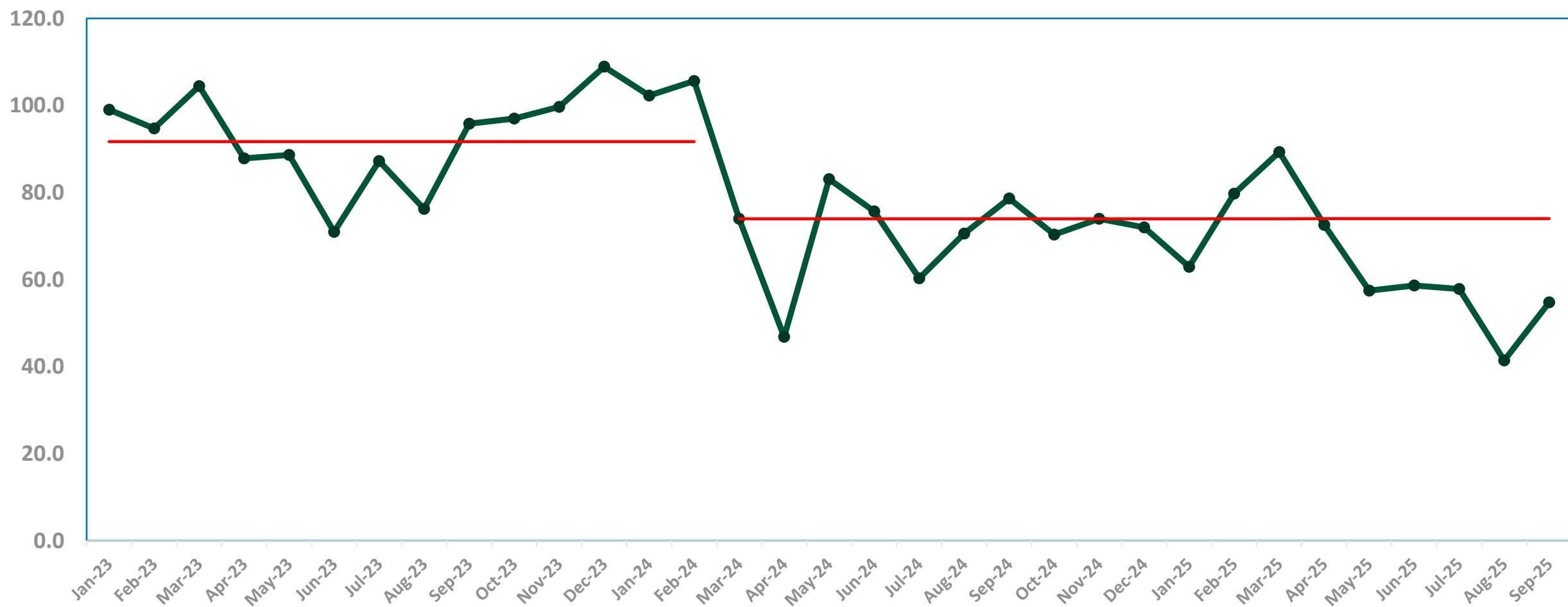


KEEPING  FAMILIES TOGETHER

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

Our outcome

Rate of Term Neonatal Admissions / 1000 term births



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

