SPSP Stillbirth Change Package

2023 Stillbirth Driver Diagram

Healthcare Improvement Scotland | Scottish Patient Safety Programme

What we are trying to achieve…	We need to ensure…	Which requires…
Reduction in stillbirth *By [locally agreed %] by 31ST March 2025*	Person centred care* considers the Continuity of Carer approach	Women / birthing people and families listened to and included in all care decisions
		Inclusive care pathways which provide equitable and culturally appropriate access and treatment
		Awareness of altered fetal movements
		Support for women / birthing people to make healthy lifestyle choices
		Bereavement support for women / birthing people and families
	Effective fetal monitoring	Risk assessment for fetal growth restriction
		Interventions to prevent fetal growth restriction
		Surveillance of fetal growth restriction
		Effective fetal monitoring antenatally and during labour
	Safe communication*	Use of standardised tools for communication
		Management of communication
	Leadership to promote a culture of safety at all levels*	Psychological safety
		Staff wellbeing
		System for learning
		Safe staffing

Essentials of Safe Care

Core programme measures

Reduction in stillbirth

By [locally agreed %] by 31 March 2025

Rate of stillbirths

Primary Driver

Person centred care considers the Continuity of Carer approach

Secondary Driver	Change ideas						
Women / birthing people and families listened to and included in all care decisions	Implement CoC model of care	1: 1 care in labour and birth and immediate postnatal period	Co-produced person centred care plan including documentation of risks revisited at each antenatal contact	Person centred language is promoted and used (e.g. RCM Re:Birth) in all settings	Consider use of digital and IT systems where appropriate e.g. Near Me	Use of evidence based parent education and signposting to inform birth plans e.g. BRAINS / It's OK To Ask	Use of a universal wellbeing assessment which identify vulnerability and protected characteristics
Inclusive care pathways which provide equitable and culturally appropriate access and treatment	Co-produced person centred care plans consider ethnicity, deprivation and individual communication needs	Social determinants addressed through onward referral to appropriate services	Staff afforded flexibility to provide care proportionate to need for those experiencing severe and multiple disadvantage	Staff able to identify, challenge and change the values, structures and behaviours that perpetuate systemic racism	Local education for staff to enable support for those experiencing severe and multiple disadvantage	Provision of timely interpretation services support	
Awareness of altered fetal movements	Individualised discussion and written information regarding importance of altered fetal movement by 28 weeks	Use of Teach-back to ensure women / birthing people understand response to altered fetal movements	Local pathway for the reliable care for women reporting altered fetal movements				
Support for women / birthing people to make healthy lifestyle choices	Staff have access to education, tools and resources to inform women about risks of smoking during pregnancy	CO monitoring at booking and 36 weeks	Process in place for opt-out referral to smoking cessation services	Signpost to services to support healthy behaviour in pregnancy and beyond e.g. Ready Steady Baby / PMH Pathways / Solihull Education	Pathways include evidence based interventions to address substances harmful to health e.g. alcohol / drugs		
Bereavement support for women / birthing people and families	Implementation of National Bereavement Care Pathway	Active promotion to support services e.g. bereavement support/counselling	Opportunity for family questions that will be discussed at the SAER / PMRT	Women / birthing people are offered the opportunity to discuss their care before discharge from maternity services			

Primary Driver

Effective fetal monitoring

Secondary Driver	Change ideas			
Risk assessment for fetal growth restriction	Locally agreed risk assessment for growth restriction at booking and key points in antenatal care	Triage women / birthing people at risk to appropriate pathways	Boards consider use of digital aids to support risk assessment	
Interventions to prevent fetal growth restriction	Low dose aspirin following appropriate screening (PlGF UtAD) and risk assessment	Use of national standardised fundal height measurement	Use of national guideline to support plotting, interpreting and referral	Fundal height measurement from 24+0 weeks and plotted at antenatal check if not done within the last 2 weeks
Surveillance of fetal growth (SGA) restriction	Assessment of SGA and growth restricted fetus with clear local protocols for FGR	Local process to identify women / birthing people who require increased surveillance/ assessment e.g. multiple pregnancies	Explore use and benefits of fetal monitoring in the community (USS and CTG in a community (or home) setting)	
Effective fetal monitoring antenatally and during labour	Use of standardised intrapartum risk assessment tool	Local education competency programme to include fetal monitoring, fetal physiology and pathophysiology of fetal brain injury	Use of buddy system in providing holistic care	

Primary Driver

Safe communication

Secondary Driver	Change ideas			
Use of standardised tools for communication	Agreed local pathway for responding to concerns of women / birthing people when contacting triage	Use of SBAR at all transitions of care	Locally agreed process for escalation of any clinical concerns	Ward level safety brief informed by unit huddle
Management of communication	Agreed local workplan for staff trained in SAER / Perinatal review process	SCOTTIE / Prompt training for emergencies	MDT discussions at key intervals within a 24hr period	

Primary Driver

Leadership to promote a culture of safety at all levels

Secondary Driver	Change ideas							
Psychological safety	Access to regular clinical supervision and/or senior support and discussion	Listening to staff to identify areas for improvement	Visible supportive leadership	Structured 1:1 time	Staff aware of mechanisms available to support speaking out (including key contacts and feedback loop)			
Staff wellbeing	Staff supported to celebrate success	Access to peer support	Local process to support and learn from safety walk rounds	Promotion of National Wellbeing hub				
System for learning	Local process to keep policies and guidelines up to date and communicated timeously to staff	Implementation of local protocols and guidance that reflect national guidance	Local Process to support and learn from Safety walk rounds	SGA births reviewed by MDT for learning opportunities	Information from DATIX/SAER/PMRT/ complaints used to inform learning and improvement	Establish links with local QI support	Bereaved parents, including seldom heard groups, listened to in order to identify areas for improvement	
Safe staffing	Staff education and awareness of staffing legislation and wider workforce planning principles	Efficient and safe rostering / CoC model implemented	Real time staffing risk assessment, escalation and mitigation	Local maternity workforce data, including staffing levels, skill mix, experience etc. used to identify focus for improvement work	Perinatal service staffing levels regularly reported and discussed at site level during safety huddles			

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