

# SPSP Perinatal Change Package



#### Perinatal Driver Diagram





What we are trying to achieve	We need to ensure	Which requires					
Reduce	Person centred care* considers the Continuity of Carer approach	Women / birthing people and families are listened to and included in care decisions Person centred care planning Family centred approach with a focus on reducing separation Inclusive care pathways which provide equitable and culturally appropriate access and treatment					
Neonatal Mortality	Screening to identify woman / birthing person at high-risk of preterm birth Clear pathways to ensure ease of access for women / birthing people and families to maternity services Safe clinical and care processes*						
	Perinatal optimisation Reliable delivery of evidence based interventions Collaborative perinatal team working						
	Avoidance of elective births before 39 weeks unless medically indicated Risk assessment, appropriate monitoring and escalation in labour						
		Delivery of evidence based care to optimise postnatal transition Recognition, response and escalation of deterioration					
	· ·	Psychological safety Staff wellbeing System for learning					
		Safe staffing					

#### **Core programme measures**



SCOTTISH PATIENT SAFET

#### **Rate of Neonatal Deaths**

Rate of Preterm birth

Rate: Clinical Outcomes Composite measure (NNAP) – bloodstream infection, BPD, NEC, preterm brain injury

Rate of term admissions to Neonatal Unit

Percentage Compliance with PPWP

#### Reduce **Neonatal Mortality** and **Neonatal Morbidity by:**

- Reducing complications of prematurity
- Reducing late preterm and unexpected term admissions to NNU

By [locally agreed aim] *By 31<sup>st</sup> March 2025* 

### **Primary Driver**

Person centred care considers the Continuity of Carer approach





Secondary Driver	Change ideas									
Women / birthing people and families are listened to and included in care decisions	Local mechanisms to support a family integrated approach in all care settings 24/7	partnership encourage atte ward rounds a	partnership policy to and encourage attendance on feedl ward rounds and shared prov		•		ge families in natal service o-design	Use of a universal wellbeing assessment which identify vulnerability and protected characteristics		fy
Person centred care planning	ImplementplanCoC modelstruof careproport	d support is ned and uctured rtionate to need	Use of anticipatory care planning and bereavement support where appropriate (neonate)		enable sibling oport	ng care planning and		Principles of Trauma Inform Practice inclu- in local educa programme	ned ded tion	
Family integrated approach with a focus on reducing unnecessary separation	Delivery room resuscitation and	Delivery room ontact / cuddles when clinically appropriate	home u	-	pathways to as soon as indicated Use of digital systems to maintain effective communication when parents are unable to visit			Use of nat agreed ho passpo	ospital	
Inclusive care pathways which provide equitable and culturally appropriate access and treatment	Co-produced person centred care plans include 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		e s	Local education for staff to enable support for those experiencing severe and multiple disadvantage		Provision of timely interpretation services support	Documented discussion about signs, symptoms and response to possible pre-term labour

# Primary Driver Reduction in preterm birth

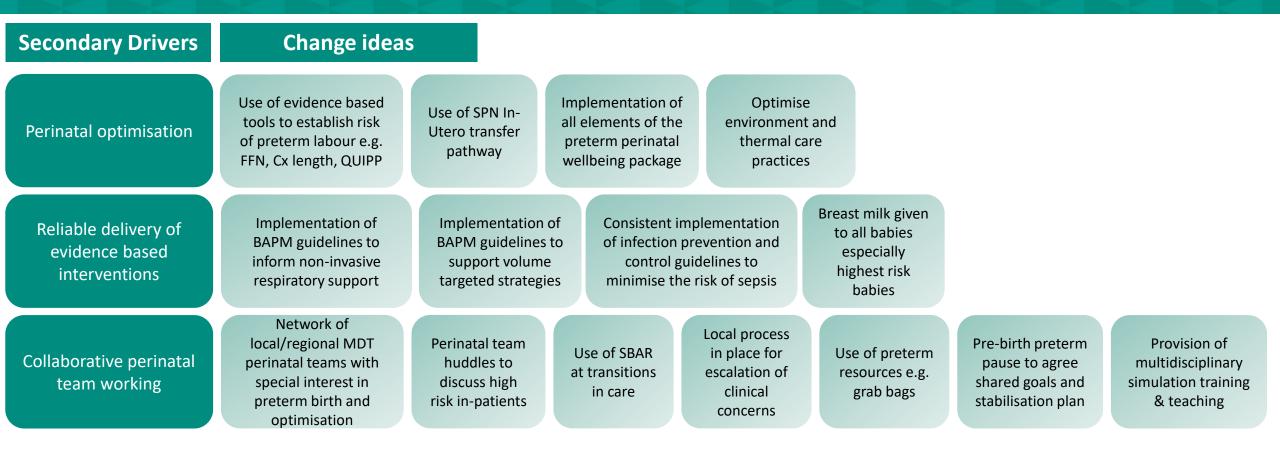




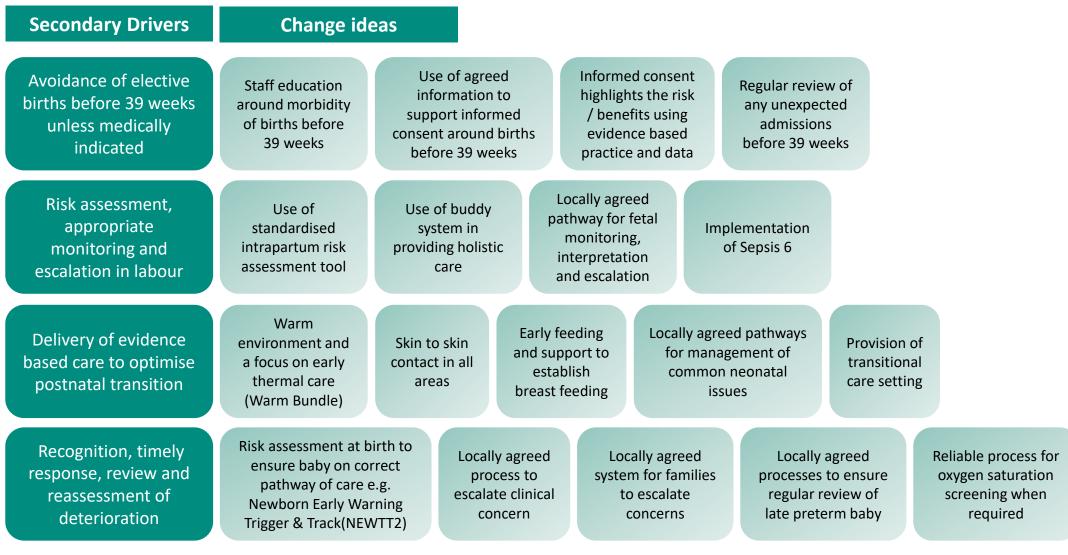
Secondary Drivers	Change i	deas								
Identify woman / birthing person at high-risk of preterm birth	Screening process and risk assessment includes social determinants/ethnicity to identify and monitor women/birthing person at risk		Early multidisciplinary discussions and planning identifies social determinants/ethnicity for women/birthing people at high risk of preterm birth			Routine screening for infection and high risk conditions such as diabetes and pre- eclampsia		Locally agreed pathway to identify and monitor multiple pregnancies	,	
Clear pathways to ensure ease of access for women / birthing person and families to maternity services	support healthy behaviours in pregnancy and beyond		coration with ance teams to ort recovery in regnancy CO monitoring at booking and 36 weeks		Consider psychological therapies / nicotine replacement therapy to support smoking cessation in pregnancy		Pathways include evidence based interventions to address substances harmful to health e.g. alcohol / drugs			
Safe clinical and care processes	Low dose aspirin following appropriate screening (PIGF UtAD) and risk assessment	Implementation of local pathway for women/ birthing people reporting altered fetal movements	access totriage sysspecialistguidelines tservice e.g.staff in recopre-term birthescalation		ntation of stems and shat support ognition and of preterm our	Use of agreed information for all pregnant women/birthing people about the signs and symptoms of preterm birth and the benefits of preterm optimisation		doo benefit induct	cal processes for discussing and cumenting risks / ts of delivery options tion of labour before weeks gestation	

## **Primary Driver** Delivery of evidence based preterm care





# Primary Driver Reduction of avoidable term and late preterm admissions



Healthcare

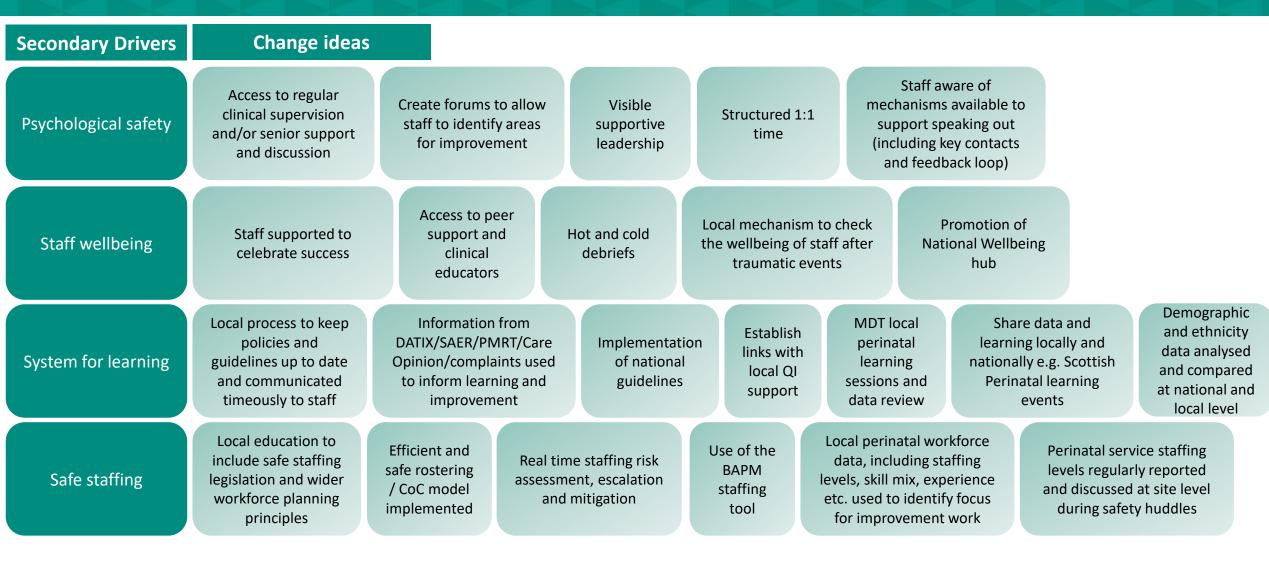
Improvement Scotland SCOTTISH PATIENT

**SAFETY** PROGRAMME









#### **Contact details**





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