How to balance clinical focus and complex systems

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Tony Kelly, Phil Duncan, Amelia Brooks, and Frank Federico have no relevant financial or nonfinancial relationship(s) within the services described, reviewed, evaluated, or compared in this presentation.
What are the objectives of this session?

- Learn how to balance clinical focus with system enablers
- Learn about the importance of narrow clinical focus to maximise perceived benefits
Introduction to IHI’s Framework for Safe, Reliable and Effective Care
The Framework in Real Life

- Culture
  - Leadership
  - Psychological Safety
  - Continuous Learning
- Improvement and Measurement
- Accountability
- Teamwork and Communication
- Negotiation
- Reliability
- Transparency

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How has the national context shifted in England?

Jeremy Hunt aims to cut number of stillbirths and neonatal deaths

UK ranked 33 out of 35 high-income countries in 2011 study on stillbirths, and has one of highest rates in Europe
What is the scale of the issue?

Stillbirths (England & Wales): 1927-2017 (ONS data)
What is the scale of the issue?

Stillbirth rate by year (England only)

Based on the 2017 ONS Birth and Death Registration data, the England stillbirth rate was 4.1 per 1,000 live births. This is a 5.1% decrease from the rate in 2016, and an 18.8% decrease since 2010.
What is the scale of the issue?

Neonatal mortality rate by year (England only)

Based on most recent Childhood Mortality data, the England neonatal mortality rate was 2.8 per 1,000 live births in 2016. This is a 5.8% decrease from the 2010 rate, but a 5.2% increase from the 2015 rate.
What is the vision of the Maternal & Neonatal Health Safety Collaborative?

To improve the **safety** and **outcomes** of **maternal and neonatal care** by **reducing unwarranted variation** and provide a **high quality healthcare experience for all women, babies and families** across maternity care **settings in England**”
What is the ambition of the collaborative?

By 2020 each Trust, local maternity system and network should have:

• significant capability (& capacity) for improvement
• detailed knowledge of local cultural issues
• developed a locally sensitive improvement plan
• made significant improvement to local service quality and safety
• data to share with their board, staff and commissioners that reflect these improvements

…to create the conditions for a safety culture and a national maternal and neonatal learning system
What is within the scope of the collaborative?

- All maternity services in England (136 Trusts)
- All care settings
- All components of the pathway (conception to puerperium) through a safety lens
How is the collaborative structured?

**National Learning Set**
(Trust Improvement)

**Local Learning Systems**
(Trust & System Improvement)
What additional support do organisations in the national learning set receive?

- Annual national learning event
- Site Support (per wave)
- Local Learning System
- Improvement & capability development (per wave)
- Access to LIFE improvement platform
- Measurement for improvement support
- Tailored resources and networks
- Wave learning sessions (per wave)
What are the tensions or polarities that can occur when running large scale improvement programmes?
Clinical

Culture
Aim of the Programme

To improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high quality healthcare experience for all women, babies and families across maternity care settings in England.

Primary Drivers

1. Build an infrastructure to support capability in safety and improvement science
2. Create a just safety culture conducive to psychological safety and effective teamwork
3. Develop a learning system that provides a methodical way to visibly capture and share positive outcomes or areas of concern, act on them and introduce a cycle of learning to improve
4. Develop the conditions required to promote effective team working and communication
5. Promote effective leadership for safety
6. Increase the knowledge and understanding of the causes of stillbirth, neonatal deaths and asphyxia births
7. Develop a measurement for improvement framework to guide quality
8. Design reliable systems and processes
9. Design effective and lean pathways of care
10. Improve reliable risk assessment, early identification, and appropriate support for women who smoke (and continue to smoke) in pregnancy
11. Improve the detection and management of diabetes in pregnancy
12. Improve the processes for the early recognition of deterioration of either mother or baby during labour
13. Improve the detection and management of neonatal hypoglycaemia
14. Increase the proportion of couples and families included in the investigation of cases of fetal death or significant harm
15. Develop effective strategies for enabling co-commissioning in local maternity systems
16. Develop new models of providing meaningful feedback on the quality of maternity services
17. Develop processes to ensure working environments for all staff are safe

Secondary Drivers

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Why did we structure work this way?

- Often policy involves “pointing’ at what is good and bad (but often poor performance) and assuming improvement will happen
- ‘Just do it’ approach to adoption and spread
- Low baseline for capability for improvement in the system
- We wanted to bring the ‘how’ to the front of the conversations alongside the ‘what’
Aim

To improve outcomes and reduce unwarranted variation by providing a safe, high quality healthcare experience for all women, babies and families across maternity care settings in England.

Reduce the rate of stillbirths, neonatal death and brain injuries occurring during or soon after birth by 20% by 2020

Primary Drivers

- Improve the proportion of smoke free pregnancies
- Improve the optimisation and stabilisation of the very preterm infant
- Improve the detection and management of diabetes in pregnancy
- Improve the detection and management of neonatal hypoglycaemia
- Improve the early recognition and management of deterioration during labour & early post partum period
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Secondary Drivers

- Creating the conditions for a culture of safety and continuous improvement
- Develop safe and highly reliable systems, processes and pathways of care
- Improve the experience of mothers, families and staff
- Learn from excellence and harm
- Improving the quality and safety of care through Clinical Excellence
Take a moment to reflect on your work…

- Can you identify system and process interventions?
- Can you identify culture and behavior interventions?
- Is there a balance in your content theory between clinical improvement and cultural improvement? Is it a tension?
- Would you consider adjusting the balance in either direction?
- Discuss in pairs or small groups
- Report out
Improvement Projects for Wave 1 Trusts

- smoke free pregnancy
- hypoglycaemia
- deterioration
- optimisation
- diabetes
- induction of labour
- growth restriction
- reduced fetal movements
- triage/flow
- post partum care
- continuity of carer
- electronic records
- risk assessment
- 3rd/4th degree tears
- caesarean pathways
- experience of care
- learning from excellence

n=133
17 topics
To improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high quality healthcare experience for all women, babies and families across maternity care settings in England.

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Improvement Projects for Wave 2 Trusts

- n=58
- 5 topics

Categories:
- Smoke free pregnancy
- Hypoglycaemia
- Deterioration
- Optimisation
- Diabetes
Aim
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Proportion of babies admitted with hypoglycaemia

National Trend

Wave 1

Wave 2

Wave 3
Take a moment to reflect on your work…

• Is your focus broad or narrow? Or a bit of both?
• Is there a balance between a broad and narrow approach? Is it a tension?
• Would you consider adjusting the balance in either direction?
• Discuss in pairs or small groups
• Report out
**Aim**

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Reduce the rate of stillbirths, neonatal death and brain injuries occurring during or soon after birth by 20% by 2020.

**Primary Drivers**

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Why did we use these interventions?

- We focused on interventions that had a clear evidence base
- Looked to avoid areas where there was a wide range of opinion on value
- Interventions where change was in the gift of clinical teams
- Where there was a known wide variation in clinical practice with associated link to variation in outcomes
- Interventions also aligned to other national initiatives
Which interventions will we support next?

- Need to acknowledge speed of change, so an argument for not broadening the focus.
- Need to learn from testing work – will our hypothesis meet the aim?
- New interventions coming on board – need to respond to external pressures.
- Developing the ‘improvement pipeline’ - as the system becomes more capable, potential to allow more local innovation for developing next wave of change ideas.
Take a moment to reflect on your work…

- What are the key interventions on which you are focused?
- Are there specific interventions that are more political in their focus?
- Is there a balance between political and clinical drivers? Is it a tension?
- Would you consider adjusting the balance in either direction?
- Discuss in pairs or small groups
- Report out
What other factors should you consider?

• There may be other polarities or tensions within your project/programme
• Where the balance sits for each is not a fixed point and may need to be adjusted in real time
• Key to effective leadership in this space is being comfortable to maintain an overview of these tensions and flex where required
• Leaders need to keep sight of the aim of the programme
What are the take home messages?

• Any programme requires a realistic goal built on evidence based interventions
• Large-scale programmes are often ‘politically’ initiated but need to resonate with clinical teams
• Improvement requires a balanced focus of clinical interventions and behavioural/cultural change
• To increase success, do fewer things well…
Thank you

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